

1

M-324 71 10001

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 71 10001

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Richard Mitchell		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 10 26 71 8:17 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 701 W. Mulberry Street		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 26 71 8:17 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10/2/06		10. AGE (In years last birthday) 65	
11. BIRTHPLACE (State or foreign country) Charleston S C		12. CITIZEN OF WHAT COUNTRY? African	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		14B. KIND OF BUSINESS OR INDUSTRY Pawn Shop	
15. MOTHER'S MAIDEN NAME Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war and dates of service) yes	
17. SOCIAL SECURITY NO. 178-18-4699		18. INFORMANT Mrs Emma Stockton, Same	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 10-26-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/29/71	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. OCT 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	

VS 151-REV. 7/1/68

10001 IV

10001 IV

ACADEMY OF DANCE

ADULT CONTEMPORARY

CLASS

10/10/11 10:00 AM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 10002</u>	
71 10002				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MR. Charles Roberts</u>		2. DATE AND HOUR OF DEATH <u>10-27-71</u> <u>6:00 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1504</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>111 Gwynn Falls Parkway 21217</u>					
5. SEX <u>MALE</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-98</u>	9. AGE (In years last birthday) <u>73</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED TAILOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>TAILOR SHOP</u>		11. BIRTHPLACE (State or foreign country) <u>British W. Indies</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>John Roberts</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Roberts</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-32-9059</u>		17. INFORMANT <u>PATIENT CHART</u>	
18. <u>570.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>UREMIA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>poss: Chronic pyelonephritis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Left - Lower Lobe PNEUMONIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>ONSET 10-25-71</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>HASCVD - old rt CVA</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10-15</u> 19 <u>71</u> to <u>10-27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10-27</u> <u>6 P.M.</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ramiro Lindado</u>		23B. DATE SIGNED <u>10-27-71</u>			
23C. PHYSICIAN'S NAME (Type) <u>RAMIRO LINDADO</u>		23D. ADDRESS <u>BON SECOURS Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11-1-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Pk.</u>	
24D. LOCATION <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 29 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Morton Dyett F.H. 1701 - N. Ave. St.</u>	

10005

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10003	
BIRTH NO. B-425		71 10003		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Blackmore, Mary			2. DATE AND HOUR OF DEATH 10-27-71 3:35 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 1512		
			C. CITY OR TOWN BALTO, Md		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2400 VIOLET AVE		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-27-09	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jessie Martin		14. MOTHER'S MAIDEN NAME Rosa Stevenson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-32-8851		17. INFORMANT Mrs. Alice Stanley 3904 Rokeby Road	
18. 152.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma of small intestine. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 10/19/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/3/71 19__ to 10/27/71 19__ that (I) (we) last saw the deceased alive on 10/27 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anjana Doshi			23B. DATE SIGNED 10/27/71		
23C. PHYSICIAN'S NAME (Type) ANJANA DOSHI M.D.			23D. ADDRESS 46 Lutheran Hospital of Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-1-71	24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 29 1971		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE.	

T-520 71 10004

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

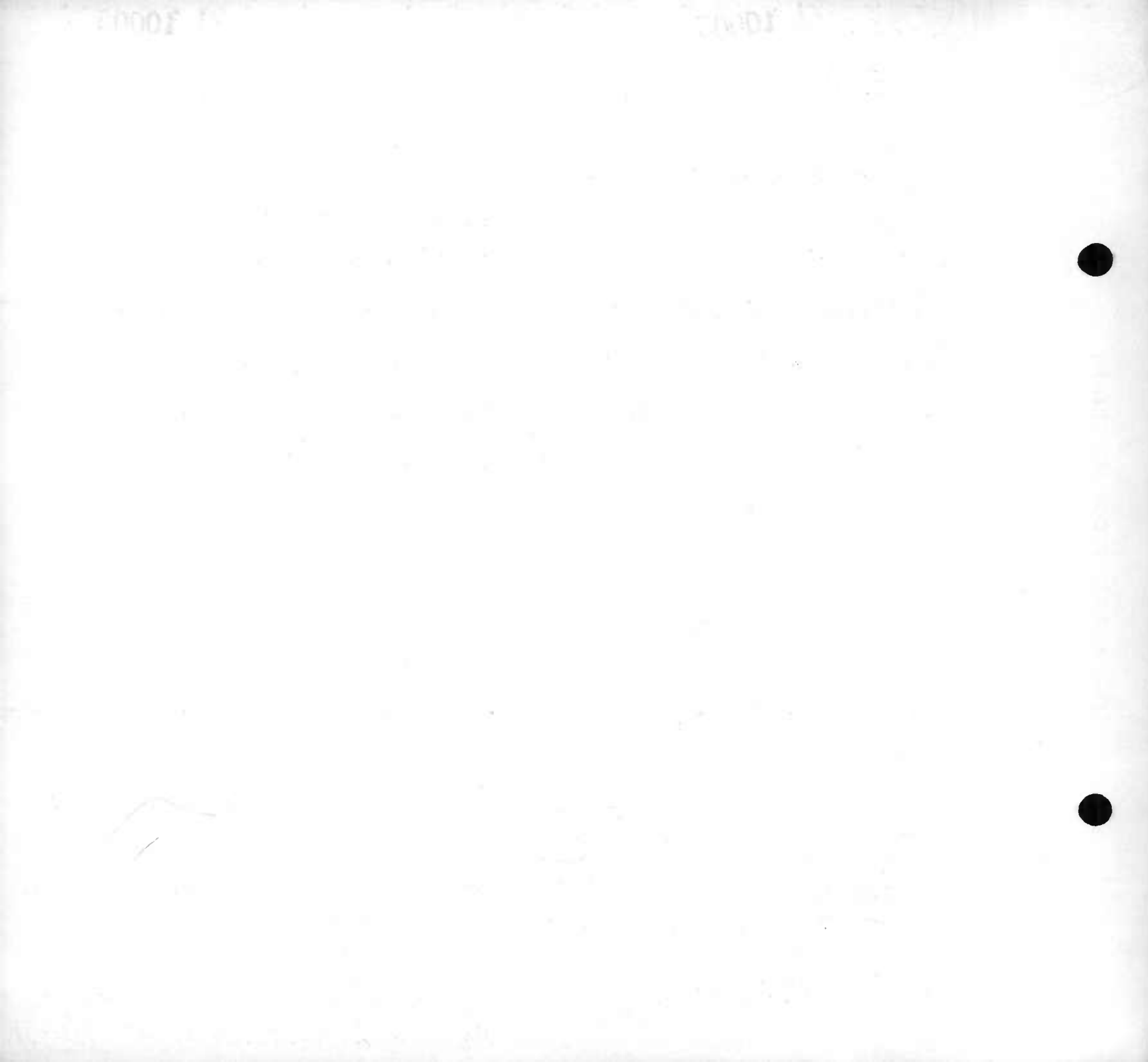
71 10004
REG. NO.

1. NAME OF DECEASED (Type or Print) George Thomas		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 10 26 71 5:50A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 16 N. Calhoun Street		3. DATE PRONOUNCED DEAD Month Day Year 10 26 71 5:05A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH JUN 06, 1928 43		10. AGE (In years last birthday) 43	
11. BIRTHPLACE (State or foreign country) Columbia SC.		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Unknown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Juanita Thomas		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Meadie Thomas 16 N. Calhoun St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTECEDENT CAUSES OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner H. Spitz, M.D. DATE SIGNED 10-26-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/29/71	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 29 1971		25B. NAME OF REGISTRAR Robert E. Gable, R.D.	
25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 3197 N. Howard St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Z-622 71 10005		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10005	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) EDWARD F. ZARACHOWICZ		2. DATE AND HOUR OF DEATH OCTOBER 25 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 103		C. CITY OR TOWN, BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 613 S. LAKEWOOD AVE.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL		10B. KIND OF BUSINESS OR INDUSTRY ARMED		8. DATE OF BIRTH 1-21-1916	
13. FATHER'S NAME JULIUS ZARACHOWICZ		14. MOTHER'S MAIDEN NAME MARYANNA OLSZEWSKI		9. AGE (In years last birthday) 55 yrs.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-10-8892		11. BIRTHPLACE (State or foreign country) MARYLAND	
17. INFORMANT MRS. CECILIA ZARACHOWICZ		ADDRESS SAME		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
18. 150X I		CAUSE OF DEATH Chronic Esophagus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-26-71 19 to 10-25 19 71 that (I) (we) lost saw the deceased alive on 9-28-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Modest Ryznycki		23B. DATE SIGNED 10-28-71		23C. PHYSICIAN'S NAME (Typed) T. W. IZNIK	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 10/28/71		24C. NAME OF CEMETERY or CREMATORY ROSARY CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTIMORE MD.		25A. DATE REC'D BY HEALTH DEPT. OCT 29 1971		25B. NAME OF REGISTRAR Raymond L. Kaczorowski	
25C. FUNERAL DIRECTOR Raymond L. Kaczorowski		ADDRESS 2525 FREET ST.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-252 71 10006

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 10006

BIRTH NO. 71 10006

1. NAME OF DECEASED (Type or Print) Stanley Casimier Jachimowicz

2. DATE AND HOUR OF DEATH October 23, 1971 8:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY 2605

5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

6. CITY OR TOWN Baltimore

7. INSIDE CITY LIMITS? YES ☒ NO ☐

8. STREET AND NUMBER 619 Umbra Street 21224

9. SEX Male

10. RACE White

11. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

12. DATE OF BIRTH 2-11-99

13. AGE (in years last birthday) 72

14. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

16. KIND OF BUSINESS OR INDUSTRY

17. BIRTHPLACE (State or foreign country) Maryland

18. CITIZEN OF WHAT COUNTRY? U.S.A.

19. FATHER'S NAME John Jachimowicz

20. MOTHER'S MAIDEN NAME Rose Gutowski

21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO

22. SOCIAL SECURITY NO. 220-01-2666A

23. INFORMANT 4940 Eastern Avenue ADDRESS
BCH: Records Baltimore, Maryland 21224

19. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF:

(B) Metastatic Carcinoma
DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from September 28, 1971 to October 23, 1971 that (I) (we) last saw the deceased alive on 23 October 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Ronald A. Griffin

23B. DATE SIGNED 23 Sept 1971

23C. PHYSICIAN'S NAME (Type) Ronald A. Griffin

23D. ADDRESS Baltimore City Hosp. 4940 Eastern Ave. Balto. Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE 10/27/71

24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.

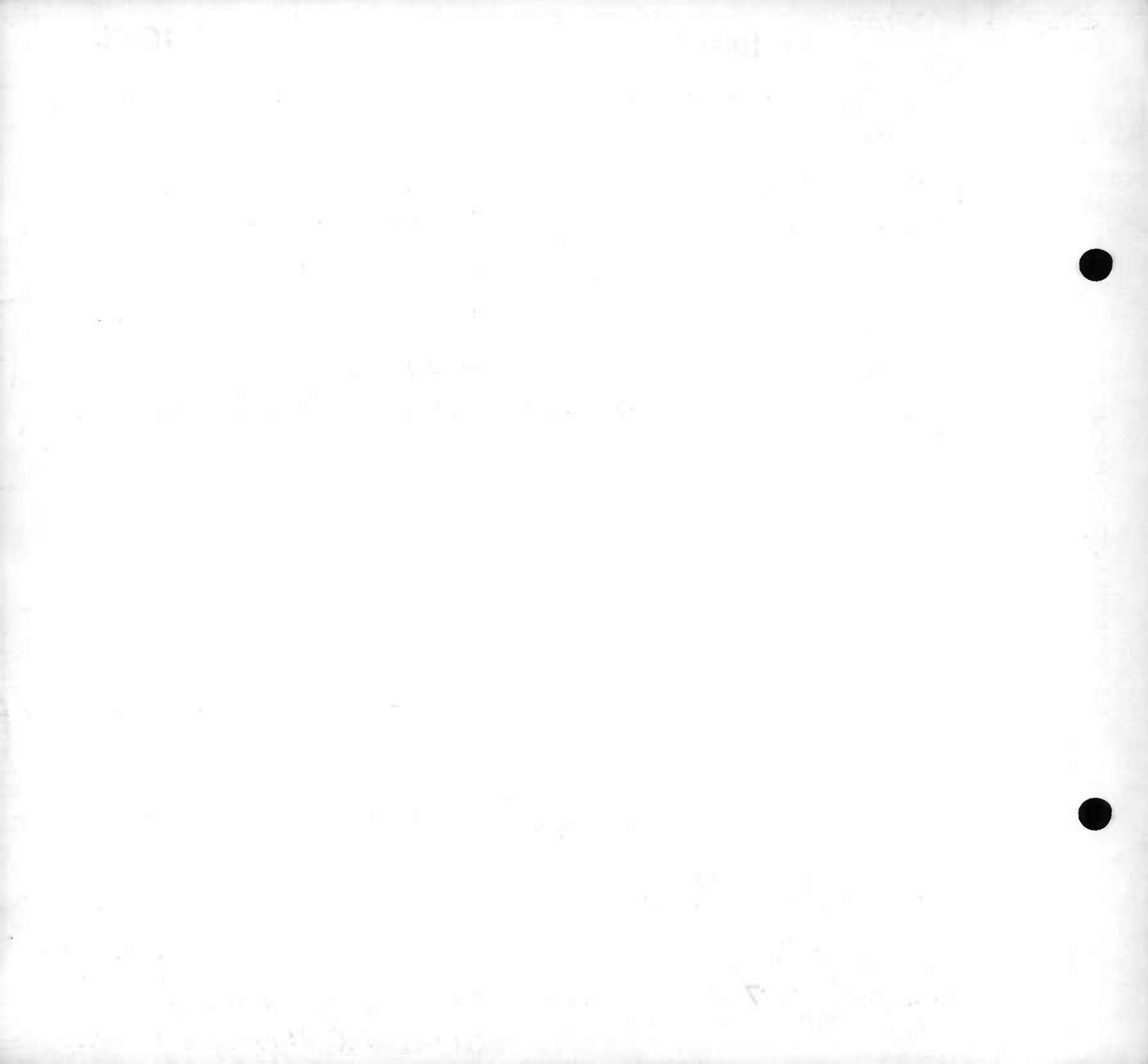
24D. LOCATION Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. OCT 29 1971

25B. NAME OF REGISTRAR Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR Raymond L. Kaczmarski

25D. ADDRESS 2525 E. St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 10007
BIRTH NO. E-640 71 10007				
1. NAME OF DECEASED (Type or Print) ALBERT EARL		2. DATE AND HOUR OF DEATH 10-27-71 1100 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Cecil		
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN Elkton D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 124 Milburn Street		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1908	9. AGE (In years last birthday) 63
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Earl		
14. MOTHER'S MAIDEN NAME Emma Adams		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 717-07-5336		17. INFORMANT Frances M. Earl- 124 Milburn Street, Elkton, Maryland		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 573.91		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METABOLIC ACIDOSIS (B) RENAL FAILURE RENAL FAILURE (C) HEPATIC FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs 16 days 16 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). SEPSIS		12 hours
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from OCT 23, 1971 to OCT 27, 1971 that (2) (we) last saw the deceased alive on OCT 27, 1971 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.		
23A. SIGNATURE Neil R. Miller MD		23B. DATE SIGNED 10-27-71		23C. PHYSICIAN'S NAME (Type) NEIL R MILLER
23D. ADDRESS Johns Hopkins Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 10/30/71		24C. NAME OF CEMETERY OR CREMATORY St. Daniels Cem.		24D. LOCATION (City, town, or county) (State) Iron Hill, Del.
25A. DATE REC'D BY HEALTH DEPT. OCT 29 1971		25B. NAME OF REGISTRAR Robert E. Barber, M.D.		25C. FUNERAL DIRECTOR Charles R. Bell
25D. ADDRESS 909 Poplar St. Wilm. Del.				

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03-03-01



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 10008	
CERTIFICATE OF DEATH				REG. NO. X	
BIRTH NO. A-352 71 10008					
1. NAME OF DECEASED (Type or Print) ADAMS Douglas H.			2. DATE AND HOUR OF DEATH 10-25-71 11:35 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital 33			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Queen Anne's 6700		
			C. CITY OR TOWN Sudlersville		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
5. SEX M	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03/17/08	9. AGE (in years last birthday) 63	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY Hauling		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William T. Adams			14. MOTHER'S MAIDEN NAME Maude E. Shagas		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 218-01-8647		17. INFORMANT Mrs. Ethel N. Adams, Sudlersville, Md.	
18. 444.21		CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Massive intestinal infarction			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Supraventricular dysrhythmia DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 10/25/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED acute abdomen		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 25 Oct 19 71 to 25 Oct 19 71 that (I) (we) last saw the deceased alive on 25 Oct 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Philip Rosenbloom, MD				23B. DATE SIGNED 25 Oct 71	
23C. PHYSICIAN'S NAME (Type) Philip Rosenbloom				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/29/71		24C. NAME of CEMETERY or CREMATORY Sudlersville Cemetery	
24D. LOCATION Sudlersville, Q.A. Md.					
25A. DATE REC'D BY HEALTH DEPT. OCT 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Edward Fellows & Son, Millington, Md.	

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71 10009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 10009

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) GILBERT LAKE, GILBERT		2. DATE AND HOUR OF DEATH 10-24-71 11:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. CITY OR TOWN Dundalk	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 6917 Holabird Ave. 21222 005	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-94	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 212-05-4351		17. INFORMANT 4940 Eastern Avenue BCH-Records Baltimore, Maryland 21224	
18. 441.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RUPTURED ABD. AORTIC ANEURYSM		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. NONE		(B) DUE TO, OR AS A CONSEQUENCE OF: NONE		HOURS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 10/24/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ABD AORTIC ANEURYSM		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from OCTOBER 24 19 71 to OCTOBER 24 19 71 that (1) (we) last saw the deceased alive on OCT. 24 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100)					
23A. SIGNATURE Geoffrey M. Graeber MD		23B. DATE SIGNED 10/24/71		23C. PHYSICIAN'S NAME (Type) Geoffrey M. Graeber MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-28-71		24C. NAME OF CEMETERY or CREMATORY Sacred Heart of Jesus	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. OCT 29 1971		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.	
25C. FUNERAL DIRECTOR John J. Duda		25D. ADDRESS 7922 Wise Ave. Dundalk, Md.		25E. ADDRESS 7922 Wise Ave. Dundalk, Md.	

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WILSON'S SPECIFIC INQUIRY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-252 71 10010				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10010	
1. NAME OF DECEASED (Type or Print) Michalina Szczesniakowski				2. DATE AND HOUR OF DEATH October 25, 1971 3:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 222 South Collington Avenue				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 105 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 222 South Collington Avenue			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-27-02	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? Poland	
13. FATHER'S NAME Michael Lempert				14. MOTHER'S MAIDEN NAME Catherine Wall			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-30-5001-D		17. INFORMANT Son: 222 S. Collington Ave Balto. Md. 21231 Mr. Adam Szczesniakowski			
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Cardio Respiratory Failure</i> <small>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Hypertensive A.S.C.U.D. Abnormal</i>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary Embolism</i>		5 years	
19A. DATE OF OPERATION <i>April 1971</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>P.C.B. Left Hemiparesis</i>		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MAR 24 15 19 71 to October 11 19 71 that (I) (we) last saw the deceased alive on October 11 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Alejandro Mesia, MD</i>				23B. DATE SIGNED 10-25-71			
23C. PHYSICIAN'S NAME (Type) ALEJANDRO MESIA MD				23D. ADDRESS St. Agnes MEDICAL CENTER Baltimore 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-29-71		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 29 1971		25B. NAME OF REGISTRAR Robert E. Fisher MD		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 21224 2829 Hudson St. Balto. Md.	

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UNRECORDED DISC ON 1/1/1974

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10011	
BIRTH NO. B-632 71 10011				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) DIETRICH F. BRETTSCHEIDER			2. DATE AND HOUR OF DEATH 27 October 1971		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 44 Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 26 31		
5. SEX Male			6. RACE Caucasian		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 26 Oct. 1902		
9. AGE (In years last birthday) 68 69			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) inspector		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Dietrich F. Brettschneider			14. MOTHER'S MAIDEN NAME Molly Tuerk		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 212-01-6436		
17. INFORMANT 6411 Mary Ave. 21206			18. CAUSE OF DEATH Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive - arteriosclerotic cardiovascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) 10 years		
19. DATE OF OPERATION 0			20. AUTOPSY? (Yes or No) no		
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			22. I certify that (I) (this hospital) attended the deceased from 12.12.1969 to 10.20.1971 , that (I) (we) last saw the deceased alive on 10.20.1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE Adam Swiss			23B. DATE SIGNED Oct. 28, 1971		
23C. PHYSICIAN'S NAME (Type) Adam Swiss, MD			23D. ADDRESS 5000 Belair Rd. 21206		
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 30 Oct 71		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) Balto. Co., Md.		24E. HOW DID INJURY OCCUR?		24F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
25A. DATE REC'D BY HEALTH DEPT. OCT 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Ulrich Funeral Home, Balto., Md. 21206	

Letter from Funeral Director 11-5-71 M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10012	
M-660 71 10012		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MAURER MRS. MARGARET M.	
2. DATE AND HOUR OF DEATH 10/26/71 8 3:45 P.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME AND HOSPITAL	
C. CITY OR TOWN DUNDALK		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 2124 DUNDALK AVE. 21222			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-20-05
9. AGE (In years last birthday) 66		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) OHIO	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Roy Nelson	
14. MOTHER'S MAIDEN NAME DELLA GALLOP		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]	
16. SOCIAL SECURITY NO. 911-19-0469		17. INFORMANT ADDRESS MICHAEL A. MAURER 8124 DUNDALK AVE	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)			
19A. DATE OF OPERATION 11/02/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CAECAL VOLVULUS	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. HOW DID INJURY OCCUR?	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/8/71 to 10/26/71 and that (I) (we) last saw the deceased alive on 19/ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE T. Sree Ramamurthy		23B. DATE SIGNED 10/26/71	
23C. PHYSICIAN'S NAME (Type) T. SREE RAMAMURTHY		23D. ADDRESS Church Home and Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 29 OCT. 71	
24C. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		24D. LOCATION (City, town, or county) (State) Baltimore M.D. - 21237	
25A. DATE REC'D BY HEALTH DEPT. OCT 29 1971		25B. NAME OF REGISTRAR Robert E. Tabor, M.D.	
25C. FUNERAL DIRECTOR ADDRESS		ULMER & FOWLER, HOME, DUNDALK, MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPT.				CERTIFICATE OF DEATH		REG. NO. 71 10013	
S-462 BIRTH NO.		71 10013					
1. NAME OF DECEASED (Type or Print) Eva Sellers				2. DATE AND HOUR OF DEATH 10/28/71 2 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 2572			
FULL NAME OF HOSPITAL OR INSTITUTION South Balto. General 43		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/12/99	
9. AGE (In years last birthday) 71		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. Carolina	
13. FATHER'S NAME Edward Lindsay				14. MOTHER'S MAIDEN NAME Atha Harris			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 251 03-10890		17. INFORMANT Hospital chart		ADDRESS	
16. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ASCVD + Rheumatoid ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Abtrial Fibrillation + CHF Cerebral arteriosclerosis				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs 2 yrs 5 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/11 19 71 to 10/28 19 71 that (I) (we) lost saw the deceased alive on 10/28 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stanford J. Huber MD				23B. DATE SIGNED 10/28/71		23C. PHYSICIAN'S NAME (Type) Stanford J. Huber MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov 1 1971		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Blen Burnie Md Ritchie Hwy	
25A. DATE REC'D BY HEALTH DEPT. OCT 29 1971		25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR ADDRESS McJully Funeral Home 237 Patapsco Ave 21225			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10014</u>
BIRTH NO. <u>4-142 71 10014</u>				
1. NAME OF DECEASED (Type or Print) <u>ALBERTA HOEFLICH</u>		2. DATE AND HOUR OF DEATH <u>10/22/71</u> <u>2</u> <u>P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>GOOD SAMARITAN HOSPITAL</u> <u>5601 LOCH RAVEN BOULEVARD</u> <u>BALTIMORE, MARYLAND 21212</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE CITY</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5657 PURDUE AVE. APT. A</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01-14-95</u>	9. AGE (in years lost birthday) <u>76</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOHN SCHMIDT</u>		
14. MOTHER'S MAIDEN NAME <u>AMELIA CONRAD</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>809E1600352240</u>		17. INFORMANT <u>EDITH HOEFLICH</u> ADDRESS <u>SAME</u>		
18. <u>41231</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Heart disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) DUE TO, OR AS A CONSEQUENCE OF:</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>cerebrovascular accident @ hemiplegia</u>				
19A. DATE OF OPERATION <u>10/26/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>10/22/71</u> to <u>10/22/71</u> and that (I) (we) last saw the deceased alive on <u>10/22/71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>I.A. Orer M.D.</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>I.A. Orer M.D.</u>
23D. ADDRESS		23E. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/26/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Taylor Ave Balto</u>		24E. DEGREE		
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 29 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Mitchell Wiedefeld Home</u>
25D. ADDRESS <u>6500 York Rd</u>				

1901



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 10015	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Raymond E. Specht RAYMOND SPECHT		2. DATE AND HOUR OF DEATH OCTOBER 25 '71 1:50 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) A. STATE BALTIMORE B. COUNTY MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4544 KESWICK RD.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 04/26/1900	9. AGE (in years last birthday) 71	10. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret I.B.M. man Maryland Casualty Co.				10B. KIND OF BUSINESS OR INDUSTRY Penna		11. BIRTHPLACE (State or foreign country) Penna	
13. FATHER'S NAME AARON SPECHT				14. MOTHER'S MAIDEN NAME EMMA RAHAUSER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 212-03-9489A				16. SOCIAL SECURITY NO. 212-03-9489A		17. INFORMANT ADDRESS Mrs. Raymond E. Specht 4544 Keswick Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. SHOCK ISCHEMIC BOWEL DISEASE ARTERIO SCLEROSIS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/22 1971 to 10/25 1971 that (I) (we) lost saw the deceased alive on 10/25 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED 10/25/71		23C. PHYSICIAN'S NAME (Type) LESLIE UHLMAN INTERN	
23D. ADDRESS 33rd and Calvert St				23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/28/71		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn Maryland	
25A. DATE REC'D BY HEALTH DEPT OCT 29 1971				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home 6500 York Road	



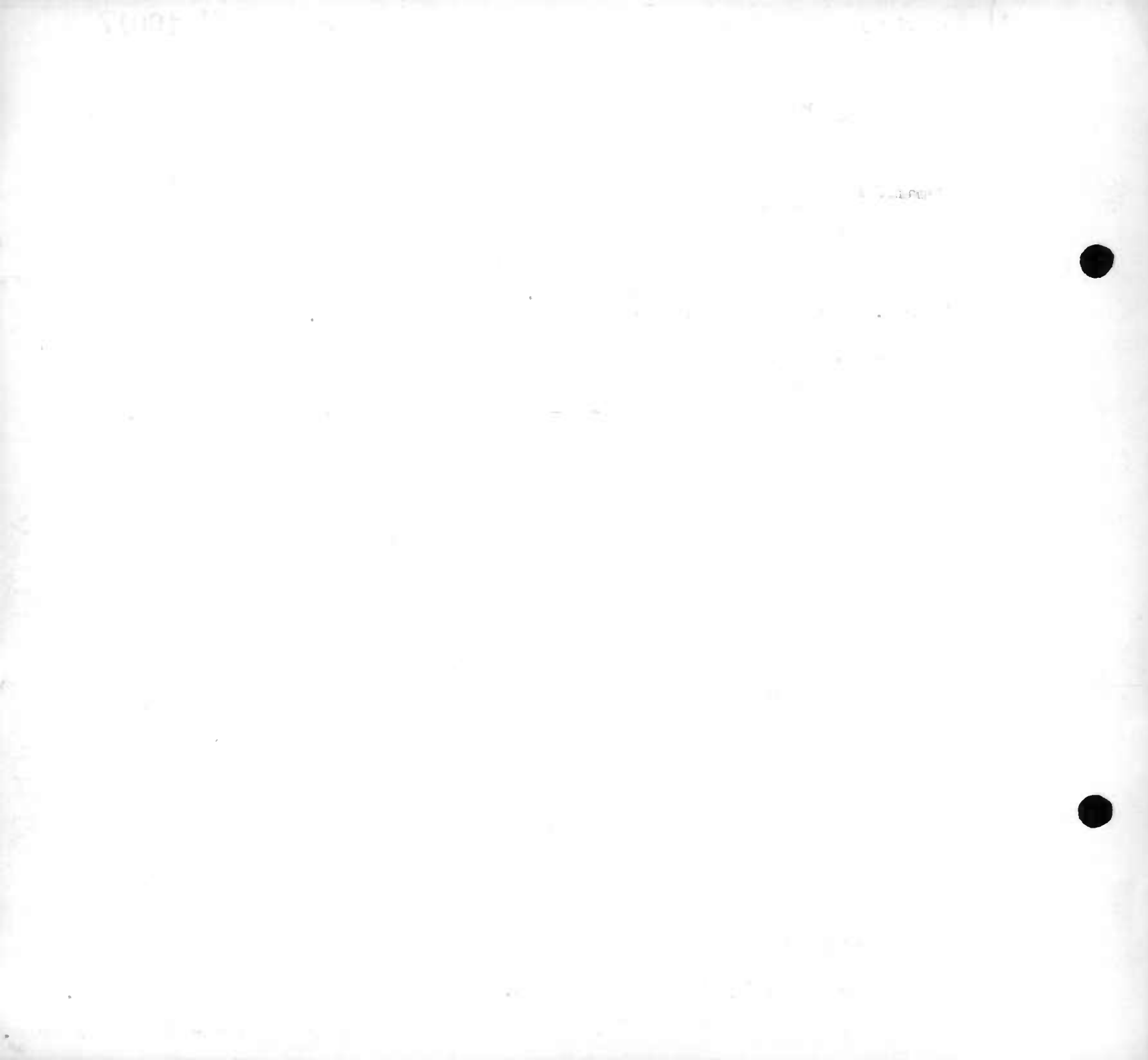
BALTIMORE CITY HEALTH DEPARTMENT		71 10016	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH		71 10016	
BIRTH NO.			
1. NAME OF DECEASED (Type or Print) Glenn Holdsworth		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 10 26 71 10:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 26 71 10:00 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 12/13/18		10. AGE (in years last birthday) 52	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Foreman		14B. KIND OF BUSINESS OR INDUSTRY Bodine Mfg. Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 235-18-1368	
15. MOTHER'S MAIDEN NAME Evelyn Lee		18. INFORMANT Wm. Sexton-319 Bryanstone Rd. 21136	
19. CAUSE OF DEATH 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10-26-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/29/71	
24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 29 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Donovan Funeral Home-3818 Roland Ave.		ADDRESS	

110016

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-500		71 10017		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10017	
1. NAME OF DECEASED (Type or Print) LAMIE, GEORGE				2. DATE AND HOUR OF DEATH 10/24/71 10:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL of BALTIMORE				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6120 FALLS RD. #9			
5. SEX MALE	6. RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/1908	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maint. Man		10B. KIND OF BUSINESS OR INDUSTRY Rockland Bleach		11. BIRTHPLACE (State or foreign country) USA Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jas. Lamie				14. MOTHER'S MAIDEN NAME ? Asbury			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 213-28-2606		17. INFORMANT ADDRESS Flora Lamie - 6120 Falls Rd. 21209			
18. 412.41 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) ACVD; CHF; CHRONIC OBST. CUNO DL. DUE TO, OR AS A CONSEQUENCE OF: (C) GI Bleeding		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> Notify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/18 19 71 to 10/24 19 71 that (I) (we) last saw the deceased alive on 10/24 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Donald P. Anderson, Jr.				23B. DATE SIGNED 10/24/71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) APPROVED T. ORDINANCE, JR. M.D.		23D. ADDRESS SINAI Hosp. of BALTIMORE					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/29/71	24C. NAME of CEMETERY or CREMATORY Moreland Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. OCT 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS Donovan Funeral Home - 3818 Roland Av			



71 10018		BALTIMORE CITY HEALTH DEPARTMENT		71 10018	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <u>Ollie Mae or Ola Silby</u> <u>Ollie M. HUNTER</u>			2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 1404 N. Central Avenue</u>			3. DATE PRONOUNCED DEAD Month Day Year Hour <u>October 26, 1971</u> <u>4:31 P.</u>		
6. SEX <u>Female</u>			5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>909</u>		
7. RACE <u>Negro</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <u>8-1-1923</u>		10. AGE (In years last birthday) <u>48</u>		E. STREET AND NUMBER <u>1404 N. Central Avenue</u>	
11. BIRTHPLACE (State or foreign country) <u>Sumter, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Ollie BRISBON</u>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		14B. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		15. MOTHER'S MAIDEN NAME <u>Ella Suckey</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		17. SOCIAL SECURITY NO.		18. INFORMANT <u>Rosalee McGee</u> ADDRESS <u>1743 Montpelier St.</u>	
19. <u>E 9651 X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH <u>Gunshot wound of neck</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
20A. DATE OF OPERATION <u>10-26-71</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>yes</u>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>1404 N. Central Avenue</u> <u>909</u>	
22D. TIME OF INJURY (APPROX.) <u>10-26-71</u> <u>P.M.</u>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>Shot by boyfriend</u>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Ronald N. Kornblum</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Ronald N. Kornblum, M.D.</u> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10/26/71</u> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-30-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Anne Arundel Co.</u>		24E. (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 29 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Randolph J. Collick</u> ADDRESS <u>2431 E. Oliver St.</u>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10019
BIRTH NO. B-420		71 10019		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) JOSEPH BLASY		2. DATE AND HOUR OF DEATH 10/28/71 11:25 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD MARYLAND GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 25.33		
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-Maint. Rev. Copper & Brass		8. DATE OF BIRTH 3-24-18		9. AGE (In years last birthday) 53
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John BLASY		14. MOTHER'S MAIDEN NAME Elizabeth Agnes		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		6. SOCIAL SECURITY NO. 29-03-4719		17. INFORMANT HOSPITAL ADMISSION RECORD
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Acute Right Coronary Thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) Arteriosclerotic Cardiovascular Disease - years		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes Mellitus				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (H) (this hospital) attended the deceased from 10-25 19 71 to 10-28 19 71 that (I) (we) last saw the deceased alive on 10-28 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Donald H. Hislop M.D.				23B. DATE SIGNED 10/28/71
23C. PHYSICIAN'S NAME (Type) DONALD H. HISLOP		23D. ADDRESS BALTIMORE, MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-1-71		24C. NAME of CEMETERY or CREMATORY Cedar Hill
24D. LOCATION Ba Ho. Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971		
25B. NAME OF REGISTRAR Robert E. Fisher, R.D.		25C. FUNERAL DIRECTOR McCully - 237 Latapso Ave. Balto Md		



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Clement Guinn				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 10 Day 28 Year 71 Hour 10:45 P.M. Estimated <input type="checkbox"/>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1519 Church Street				3. DATE PRONOUNCED DEAD Month 10 Day 28 Year 71 Hour 10:45 P.M.			
6. SEX male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Jan. 14, 1915				10. AGE (In years last birthday) 56		11. BIRTHPLACE (State or foreign country) Allegany Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Norman Guinn			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				15. MOTHER'S MAIDEN NAME Bertie Snyder		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 220-10-2103				18. INFORMANT Family - same as # 5			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 yrs + 2509			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Diabetes				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes				20A. DATE OF OPERATION 11-1-71			
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED no				21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 11-1-71				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Peter Lipkovic, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/29/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-1-71		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, AA Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Mc Cully 130 E. Fort Ave. Balto. Md. 21230	

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 71 10021	
1. NAME OF DECEASED (Type or Print) PAUL E. KIAH				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL (DOA)				3. DATE PRONOUNCED DEAD Month Day Year Hour October 23, 1971 12:54 A.M.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1509				C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX Male		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 3849 Forest Park Avenue	
9. DATE OF BIRTH 4-16-20		10. AGE (In years lost birthday) 51		11. BIRTHPLACE (State or foreign country) Portsmouth, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unk.				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			
15. MOTHER'S MAIDEN NAME Evelyn Kiah				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes			
17. SOCIAL SECURITY NO. 230-14-1092				18. INFORMANT Wright 107 Mrs. Viola Albermarle St. Apt. 5D 21202			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Gunshot wound of left chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes				22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3200 block W. North Avenue 1506			
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 10-23-71 12:33 A.M.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22F. HOW DID INJURY OCCUR? Shot during altercation				23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/23/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-01-71		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A.A. Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213 Marshall W. Jones, Jr.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		71 10022	
1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH		REG. NO.	
TEMPLE K. MERCHANT		Oct 25, 1971		9:45 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland		2733	
Church Home & Hospital		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. DATE OF BIRTH		9. AGE (in years last birthday)	
M	W	5/2/18		53	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		W. Va.		U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY			
(-)		unknown			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Ray Merchant		Esther McDonald			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
unknown		236 192500		mother	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		few days	
ANTECEDENT CAUSES		(B) Chronic liver disease		20 years?	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) portal cirrhosis (?)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10/5/71 to 10/25/71 that (I) (we) last saw the deceased alive on 10/25/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Gemma P. Indolos MD		10/25/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
GEMMA P. INDOLOS MD		church Home & Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
burial		10/28/71		Edgehill Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 1 1971		Robert E. Taylor, M.D.		Higinbotham Black & H. Ellis	
				Charlestown SW. Va.	

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 10023

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Francis G. Guerke

2. DATE AND HOUR OF DEATH

October 26, 1971

3:30 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Queen Anne's

C. CITY OR TOWN

Stevensville

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

P.O. Box

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

3-20-02

9. AGE (in years
last birthday)

69

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Barber

10B. KIND OF BUSINESS OR INDUSTRY

Motel

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Francis

Guerke

14. MOTHER'S MAIDEN NAME

Sarah

Joyner

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

228108793

17. INFORMANT

BCH RECORDS:

4940 Eastern Avenue
Baltimore, Maryland 21224APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiac Arrest

(B)

DUE TO, OR AS A CONSEQUENCE OF:

ASCVD / COPD.

(C)

Reticulum Cell Sarcoma.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/20/1971 to 10/26/1971
that (I) (we) last saw the deceased alive on 10/26 at 3:30 PM 1971 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Paul Wheaton

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

10/26/71

23C. PHYSICIAN'S
NAME (Type)

PAUL WHEATON

23D. ADDRESS

BALTIMORE CITY HOSP.

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

City, town, or county

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 1 1971

25B. NAME OF REGISTRAR

Robert E. Fisher, R.D.

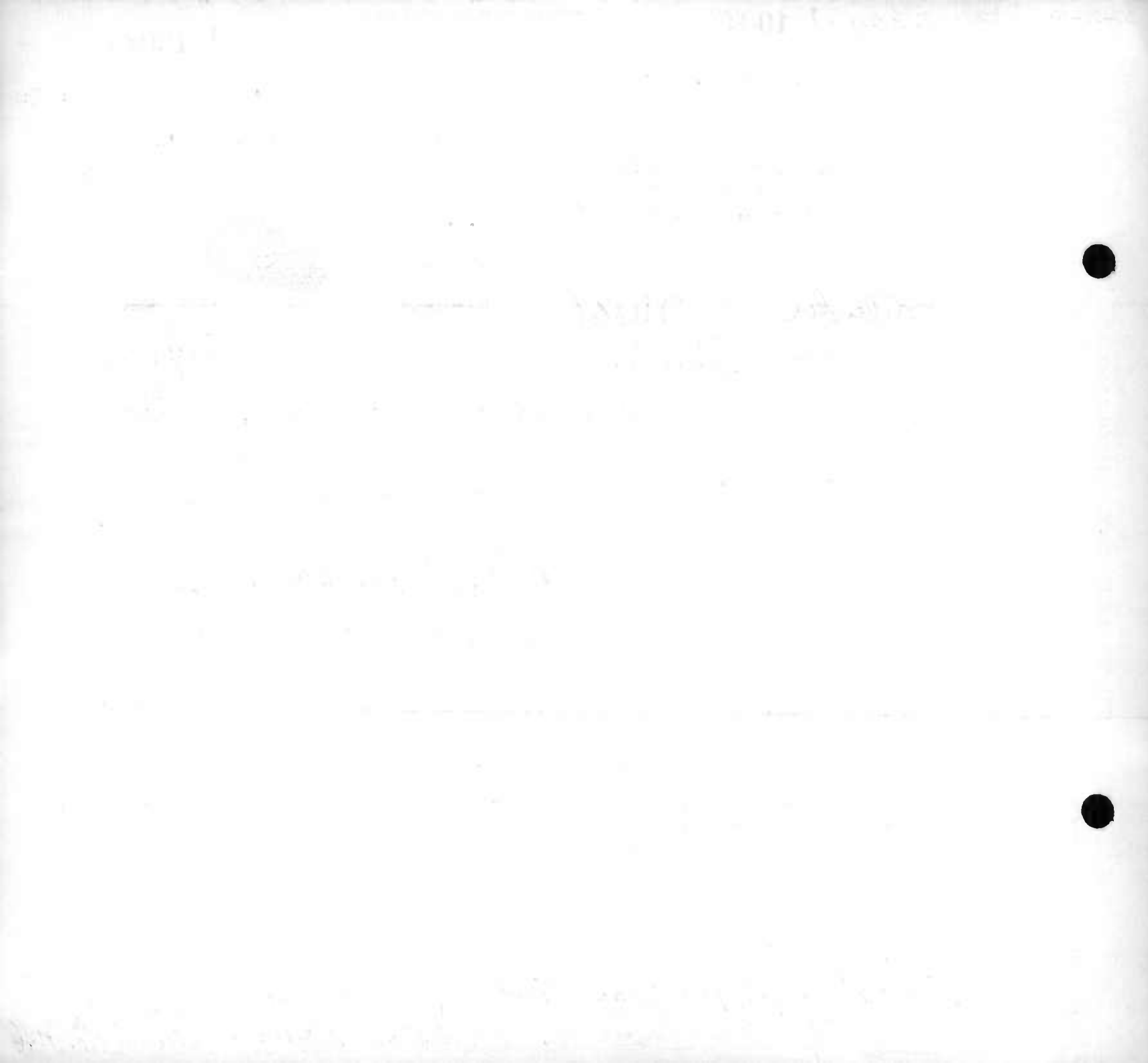
25C. FUNERAL DIRECTOR

ADDRESS

Robert S. Benard Arena Pl. Md.

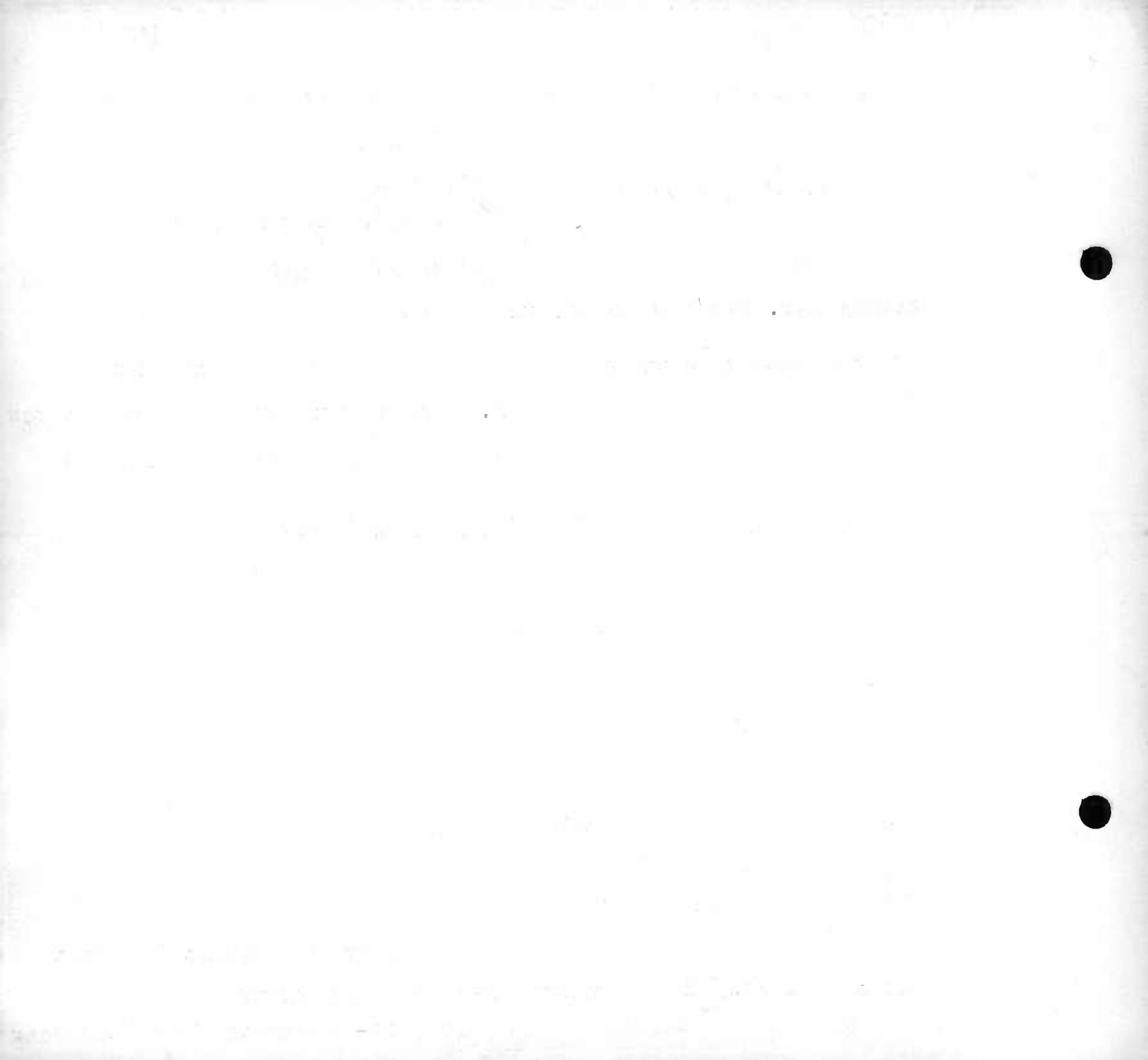
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. R-556 71 10024		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 10024	
1. NAME OF DECEASED (Type or Print) Reinheimer, Emma Pauline			2. DATE AND HOUR OF DEATH Oct 27 1971 1 10 PM.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hosp.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 21239		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1502 Pentridge Rd, Apt 116		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04-11-07	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXX RET. SEC'Y HOOD RUBBER			10B. KIND OF BUSINESS OR INDUSTRY Penn.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME GEORGE EDWARD REINHEIMER			14. MOTHER'S MAIDEN NAME ? NESENTHALER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. MR. ARTHUR REINHEIMER 500 STONELEIGH		
17. INFORMANT ADDRESS MR. ARTHUR REINHEIMER 500 STONELEIGH					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4-32-71 cerebral infarct			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Basilar artery thrombosis		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Cirrhosis					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 10/14 19 71 to 10/27 19 71 that (1) (we) last saw the deceased alive on 10/27 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Victor J. Rogosa, M.D.			23B. DATE SIGNED 10/27/71		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS MARYLAND GENERAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/29/71		24C. NAME OF CEMETERY OR CREMATORY OAKLAWN CEMETERY	
				24D. LOCATION (City, town, or county) (State) BALTIMORE	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.		25C. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME	
				ADDRESS 6500 YORK	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>71 10025</u>	
BIRTH NO. <u>H-163</u>		71 10025		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>HUBBARD, Sherry</u>				2. DATE AND HOUR OF DEATH <u>10/28/1991</u> <u>7:50 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD</u>		B. COUNTY <u>Kent</u>	
				C. CITY OR TOWN <u>ROCK HALL</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>P.O. Box 183</u>			
5. SEX <u>FEM</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>09/01/1949</u>		9. AGE (In years last birthday) <u>22</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>COPLAND HUBBARD</u>				14. MOTHER'S MAIDEN NAME <u>ELEANOR ASHLEY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215 62 0149</u>		17. INFORMANT ADDRESS <u>Copeland Hubbard - Rock Hall, Md.</u>			
18. <u>571.9 I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory and Cardiac Arrest</u>			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(B) <u>Hepatic and Renal insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(C) <u>Chronic Hepatitis - Bowel Gangrene</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>10/18/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bowel Gangrene</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10/16/1991</u> 19 <u>71</u> to <u>10/28</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>10/28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10/28/1991</u>	
23C. PHYSICIAN'S NAME (Type) <u>RONALDO S. CARNEIRO</u>				23D. ADDRESS <u>33rd & Calvert sts.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/31/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>near Rock Hall, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 1 1991</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Chestertown, Md.</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10026</u>	
P-463 71 10026					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
POLLARD, JOHN HENRY		October 27, 1971 4:35 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218		MARYLAND CAROLINE 5500			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
MALE		CAUCASIAN		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days	
2/19/21		50			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
MARYLAND		USA		JOHN POLLARD	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
MAMIE MURPHY		YES WW II 10-24-45 11-27-46		213-12-5415	
17. INFORMANT		ADDRESS			
CLIN RCDS, VAH, BALTIMORE, MARYLAND					
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		2 YEARS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
9/12/71		CARCINOMA, ESOPHAGUS		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from October 12, 1971 to October 27, 1971, that (X) (we) last saw the deceased alive on October 27, 1971, and that (X) (our) opinion of death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
George Berakha, M.D.				10/28/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
GEORGE BERAKHA, M.D.				VA HOSPITAL, BALTIMORE, MARYLAND 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		10/30/71		Ridgely Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME of REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 1 1971		Robert E. Gabel, R.D.		Frampton Funeral Home, Federalsburg, Md.	

35001

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 10027		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 10027	
1. NAME OF DECEASED (Type or Print) EVANS, WILLIAMS			2. DATE AND HOUR OF DEATH October 25 - 71 - 1:25		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 26088		
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX - Male 6. RACE - W. - white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 10/6/74		9. AGE (in years last birthday) 97
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Osborn J. Evans		
14. MOTHER'S MAIDEN NAME Sarah E. PERINE			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 2 14- 46 7903			17. INFORMANT BCH: RECORDS 4940 Eastern Avenue Baltimore, Maryland 21224		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 10/18/71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from May 18, 1970 to Oct 25, 1971 and that (I) (we) last saw the deceased alive on Oct 25, 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Luis Carrillo M.D.			23B. DATE SIGNED Oct-25/1971		
23C. PHYSICIAN'S NAME (Type) Luis Carrillo M.D.			23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. 21224		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 10/27/71		24C. NAME OF CEMETERY OR CREMATORY Cathlamet	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Joseph J. Zimmerno			
25D. ADDRESS 263 S. Conkling					

Adm. May '70

3405 Claremont Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10028	
BIRTH NO. H-632				71 10028	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
ABRAHAM HORWITZ				October 28, 1971 11:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
91 LEVINDALE AGED HOME				MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN	
91 LEVINDALE AGED HOME				BALTIMORE	
5. SEX				D. INSIDE CITY LIMITS?	
Male				YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
White Human		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10/15/1892	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
LABORER		BUILDING		79	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
LITHUANIA				USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
EDWARD HORWITZ				GERTIE ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
(Yes, no or unknown)				222-05-6225 A	
17. INFORMANT				ADDRESS	
MRS. SARAH HORWITZ, LEVINDALE HEBREW HOME				MRS. SARAH HORWITZ, LEVINDALE HEBREW HOME	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE PULMONARY EMBOLUS					
DUE TO, OR AS A CONSEQUENCE OF:					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
ARTERIOSCLEROTIC HEART DISEASE					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
2		2		yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from September 15 19 60 to October 28 1971 that (X) (we) last saw the deceased alive on October 28 19 71 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Theodore R. Reiff				October 28, 1971	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Theodore R. Reiff, M.D.				Levindale	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		10-29-71		BALTIMORE HEBREW	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 1 1971		Robert E. Taylor, M.D.		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

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BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. **71 10029**

BIRTH NO. **B-653 71 10029**

1. NAME OF DECEASED (Type or Print) PAUL L. BRYANT		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> October 28, 1971		Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year October 28, 1971		Hour 1:15 A.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 26 31		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH Sept. 20, 1953.		10. AGE (In years last birthday) 18		E. STREET AND NUMBER 5910 Willett Avenue	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joshua Bryant	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Teresa Heiner	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) Yes Active Duty		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mr. Joshua Bryant (Same)	
MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19. CAUSE OF DEATH E9661 Stabwound of left upper thigh with massive hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 5910 Willett Avenue 26 31	
22D. TIME OF INJURY (APPROX.) 10-28-71 12:30 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Stabbed during altercation	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED: October 28, 1971 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/1/71		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25D. ADDRESS			

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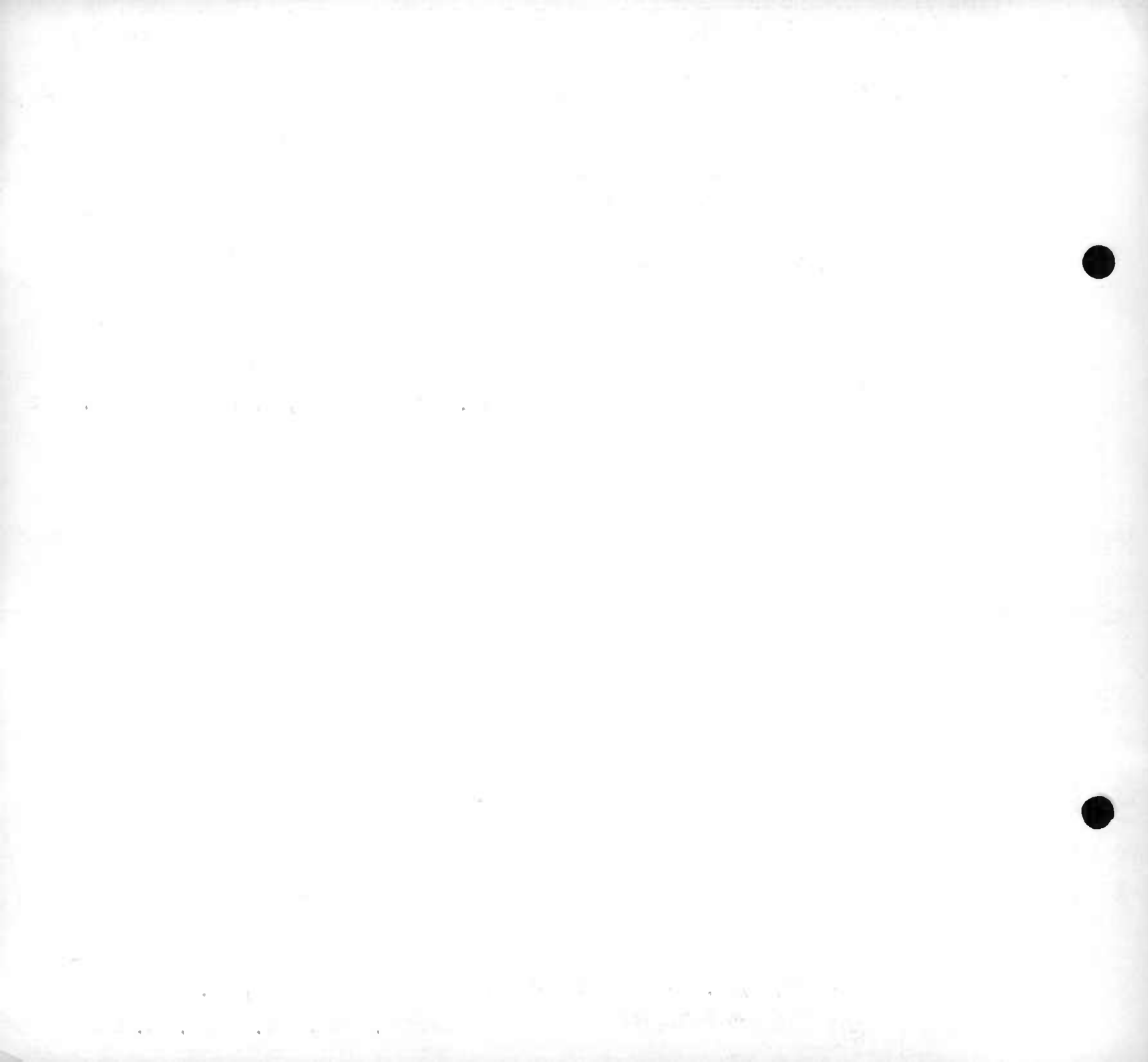
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10030	
W-420 71 10030 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mrs. K. Emma R. Wallace</i>		2. DATE AND HOUR OF DEATH <i>10 28 - 71 3: 45 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1402</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i> <i>34 Baltimore + Pulaski</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>1-25-86</i> 9. AGE (in years last birthday) <i>85</i>	
11. BIRTHPLACE (State or foreign country) <i>Texas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		13. FATHER'S NAME <i>Yarion Lyon</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-24-3427</i>		17. INFORMANT ADDRESS <i>Mrs. Weldon Wallace, 202 Witherspoon Rd. 21212</i>	
18. <i>41241</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Cerebrovascular accident</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) <i>arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10-9</i> 19 <i>71</i> to <i>10-28</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>10-28</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Marco Florez</i> M.D. DEGREE				23B. DATE SIGNED <i>Oct 28-71</i>	
23C. PHYSICIAN'S NAME (Type) <i>MARCO FLOREZ</i> M.D. DEGREE				23D. ADDRESS <i>Bon Secours Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>10/29/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Greenmount Crematory</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		24E. STATE (State) <i>Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 1 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10031	
BIRTH NO. B-460 71 10031		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CHARLES H. BLAIR Jr.		2. DATE AND HOUR OF DEATH 10-27-71 945 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSP.		A. STATE MARYLAND B. COUNTY 1902			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1533 W. LOMBARD ST.			
5. SEX MALE	6. RACE CAUC.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/98	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHARLES BLAIR		14. MOTHER'S MAIDEN NAME MABEL SIMPSON		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-16-8133		17. INFORMANT ADDRESS Hospital Records.	
18. 492X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Cachexia + Acute Gastric		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months + Hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Dilatation			
		(B) Chronic Bulous Emphysema DUE TO, OR AS A CONSEQUENCE OF:		Years	
		(C) Acute Anemia		Years	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J.P. Detrick, M.D.				23B. DATE SIGNED October 30, 1971	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 10/30/71		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) 5829 Ritchie Hwy. Balto Md		25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Thomas J. Kenny, Inc.		25D. ADDRESS 1600 Hopkins		25E. CITY Baltimore	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 10032	
1. NAME OF DECEASED (Type or Print) BABY MEREDITH		2. DATE AND HOUR OF DEATH 10/28/71 5:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Bon Secours Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 2541			
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX m 6. RACE w		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/27/71	
10A. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired]		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 6 30	
13. FATHER'S NAME William Meredith		14. MOTHER'S MAIDEN NAME Darlene		11. BIRTH PLACE (State or foreign country) USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Chart	
18. 777X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Prematurity (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 10-28-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) N/A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? N/A	
22. I certify that (I) (this hospital) attended the deceased from 10-27-71 to 10-28-71 that (I) (we) last saw the deceased alive on 10-28-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 10-28-71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) GERARDO M LOPEZ JR.		23D. ADDRESS Bon Secours Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 10/28/71		24C. NAME OF CEMETERY OR CREMATORY Bon Secours Hosp.	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. [REDACTED]
BIRTH NO. 1. NAME OF DECEASED (Type or Print) ROBERT L. WILLIAMS		2. DATE AND HOUR OF DEATH OCT. 31, 1971 - 3:04 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTO. 42 BALTO., MD., 21215		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER RUPONT AVE. 3315 # 21215		
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 17, 1903	9. AGE (In years last birthday) 68 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY U.S.A., Georgia		
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 238-14-7013		17. INFORMANT PATIENT'S CHART
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CARDIO - RESPIRATORY ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASPIRATION PNEUMONIA (B) DUE TO, OR AS A CONSEQUENCE OF: CARCINOMATOSIS FROM CA OF LUNG (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE APPROX. 1-2 hrs.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 11/4/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nasty medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from OCT. 28 19 71 to OCT. 31 19 71 that (I) (we) last saw the deceased alive on OCT. 31 19 71 and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Cayetano T. Pizon, M.D.				23B. DATE SIGNED OCT. 31, 1971
23C. PHYSICIAN'S NAME (Type) CAYETANO T. PIZON, M.D.		23D. ADDRESS SINAI HOSPITAL BALTO., MD. 21215		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/4/71		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Md		25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971		
25B. NAME OF REGISTRAR Robert E. Valley, M.D.		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W north Ave		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10034	
<div style="display: flex; justify-content: space-between;"> L-256 71 10034 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Lochenauer, John H.		10-26-71 9:03p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital			A. STATE Maryland B. COUNTY Baltimore		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
37			E. STREET AND NUMBER 200 Beaumont Av.		
5. SEX Male White	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1971	9. AGE (In years last birthday) 64	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & die		10B. KIND OF BUSINESS OR INDUSTRY Western Electric	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Henry Lochenauer			14. MOTHER'S MAIDEN NAME Mary Gunther		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-03-9518A	17. INFORMANT Mildred U. Lochenauer ADDRESS Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cachexia; Renal Failure (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Dehydration			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of the Esophagus		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Terry P. Detrick</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Terry P. Detrick				23D. ADDRESS Mercy Hospital, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		10/30/71		Lorraine Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 1 1971		Robert E. Fisher, M.D.		Edw. S. MacNabb Sons, Inc.	
				301 Frederick Rd. Catonsville, Md.	

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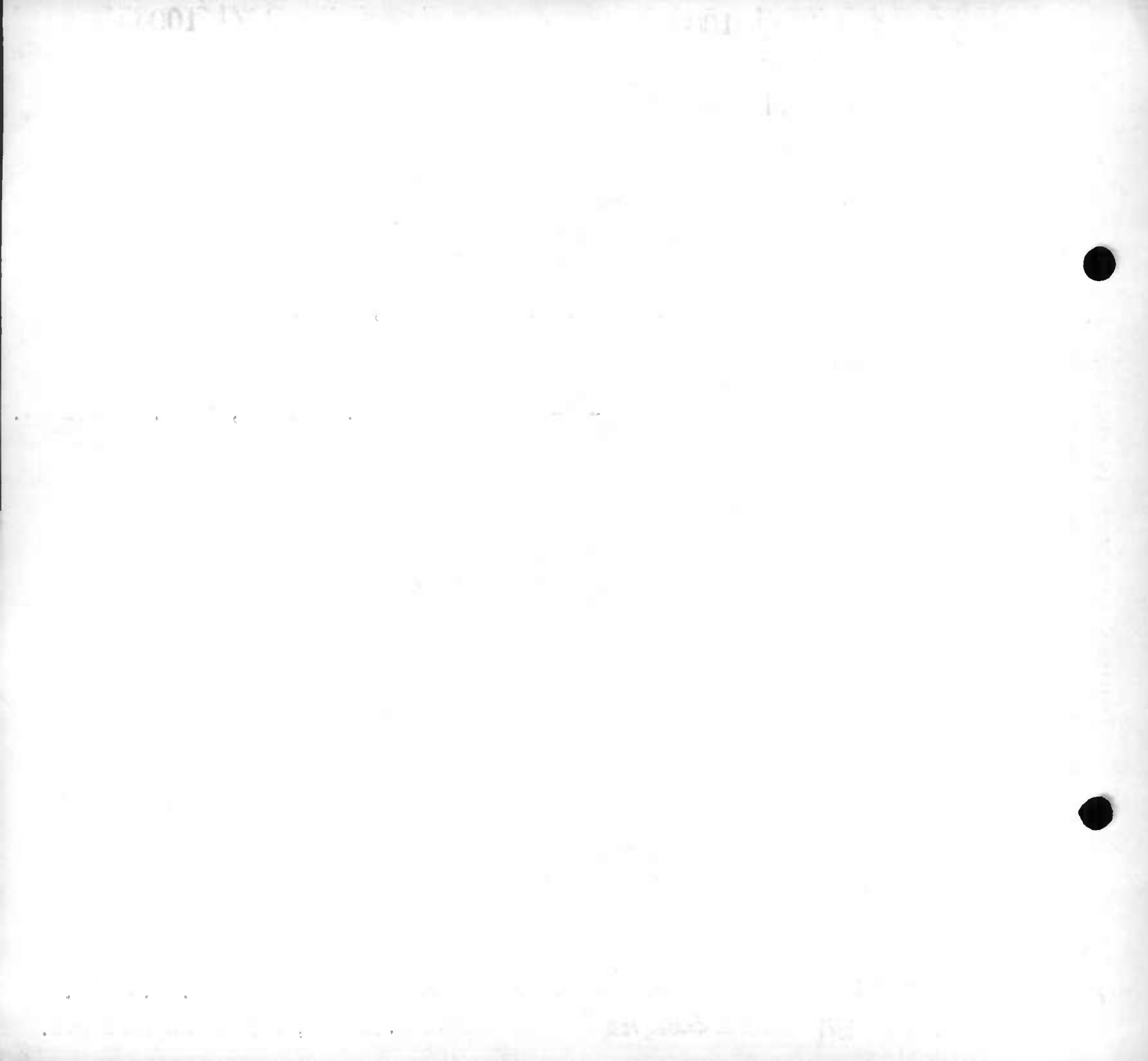
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

11-320		71 10035		BALTIMORE CITY HEALTH DEPARTMENT		71 10035	
BIRTH NO.		E.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) James Matthews				2. DATE AND HOUR OF DEATH 10/28/71 11:15 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1002			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male				6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3/26/31				9. AGE (In years last birthday) 40		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10B. KIND OF BUSINESS OR INDUSTRY Road Construction		11. BIRTHPLACE (State or foreign country) Newark, New Jersey	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Edward Matthews			
14. MOTHER'S MAIDEN NAME Ludranie Love				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 142-22-8870				17. INFORMANT Theresa T. Matthews, 926 N. Central Av.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 1				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 10/27 1971 to 10/28/ 1971 that (we) last saw the deceased alive on 10/28 1971 and that (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.				23A. SIGNATURE Harold Hederman, M.D. DEGREE			
23B. DATE SIGNED 10/28/71				23C. PHYSICIAN'S NAME (Type) Harold Hederman, M.D. DEGREE			
23D. ADDRESS Johns Hopkins Hosp, Balt. Md.				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 11/1/71				24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Arbutus (Balto. Co.) Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR EDGAR L. LYNCH, 2463 Druid Hill Ave.	



71 10036 **CERTIFICATE AMENDED** 7-18-74
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 71 10036
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Diana Dina B. JACKSON, Annie		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> October 27, 1971	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ADDRESS OR LOCATION 2019 Etting Street		3. DATE PRONOUNCED DEAD Month Day Year October 27, 1971 5:47 P.M.	
6. SEX Female		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1403	
7. RACE Negro		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 7-4-96		10. AGE (In years last birthday) 75	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Geo. Jackson		ADDRESS same	
19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> October 28, 1971			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-1-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971		25B. NAME OF REGISTRAR Reginald E. Bailey, Jr.	
25C. FUNERAL DIRECTOR Kelson FH.		ADDRESS 1348 Calhoun St.	

Birth record of child born 10-9-10
Balto. City A 60799

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. <u>71 10037</u>	
BIRTH NO. <u>0-416</u>		71 <u>10037</u>			
1. NAME OF DECEASED (Type or Print) <u>Eileen Oliver</u>			2. DATE AND HOUR OF DEATH <u>10/31/71</u> <u>1530</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bilmer. of Md. Hosp. Balt. Md.</u>			A. STATE <u>Md.</u> B. COUNTY <u>Balt.</u>		
			C. CITY OR TOWN <u>Balt.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>1102 N. Stockton St. 21217</u>		
5. SEX <u>F.</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/16/14</u>	9. AGE (in years last birthday) <u>57</u>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>So. Carolina.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>Frederick Jett</u>			14. MOTHER'S MAIDEN NAME <u>Pearl Howard</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT <u>Patant</u> ADDRESS <u>Hilda Littlejohn 1632 Lorman Ct</u>	
18. <u>747.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac arrest</u> (B) <u>severe cor pulmonale and CHF</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>patent ductus arteriosus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>2 yrs.</u> <u>57 yrs.</u>
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Indify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/30</u> 19 <u>71</u> to <u>10/31</u> 19 <u>71</u> and that (I) (we) last saw the deceased alive on <u>10/31</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. W. Mellinger MD</u> DEGREE				23B. DATE SIGNED <u>10/31/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard W. Mellinger MD</u> DEGREE				23D. ADDRESS <u>Univ. of Md. Hosp</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-5-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u>	
24D. LOCATION (City, town, or county) <u>Balto., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 1 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Bailey, R.D.</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u> ADDRESS <u>Kelson, F.H. 1348 Calhoun Street</u>			



1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived, if Institution; residence before admission)	
Annie Moss		Known <input checked="" type="checkbox"/> Month 10 Day 28 Year 71 Hour 6:15 p.m.		Month 10 Day 28 Year 71 Hour 6:15 p.m.		Provident Hospital		A. STATE Md. B. COUNTY 907	
6. SEX female		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH 3-23-33		10. AGE (In years lost birthday) 38	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel Ishway		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Leola Whitner	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Alberta Ishway 1830 Lorman St.		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Carcinoma of the rectum with metastasis		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/29/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-3-71		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT NOV 1 1971	
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR V. Bailey		25D. ADDRESS Kelson F.H. 1348 Calhoun Street					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-600 71 10039		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 10039	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) EYRE GILBERT			
2. DATE AND HOUR OF DEATH 10-29-71 10¹⁵ A.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 301 ST. PAUL PLACE		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1102		C. CITY OR TOWN BALTIMORE	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 524 N. CHARLES ST.		5. SEX M		6. RACE CAUCASIAN	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-16-1920		9. AGE (In years last birthday) 50		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY SUPERIOR COURT		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EYRE, LEE J				14. MOTHER'S MAIDEN NAME SMALLWOOD, EUDORA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN				16. SOCIAL SECURITY NO. 219-01-8731A		17. INFORMANT MRS LOUISE L. EYRE 524 N. CHARLES ST.	
18. 431-01				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY FAILURE SUBACUTE SUBDURAL				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HEMATOMA HYPERTENSION				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) HYPERTENSION			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 10/24 19 71 to 10/27 19 71 that (we) last saw the deceased alive on 10/27 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED 10/29/71		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS [Address]				23E. DEGREE		23F. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/1/1971		24C. NAME OF CEMETERY OR CREMATORY St. Mark Esp. Cemetery		24D. LOCATION (City, town, or county) (State) Highland, Maryland Howard County	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR G. Truman Schwab		25D. ADDRESS 5151 Balto. Nat'l. Pike	



MBG 3

192771

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-610		71 10040		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10040	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GROFF, Hazel L.				2. DATE AND HOUR OF DEATH 10/27/71 5:30 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital				A. STATE Maryland		B. COUNTY Baltimore	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1008 Leeds Avenue			
5. SEX FEMALE	6. RACE CAUC.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/99	9. AGE (in years last birthday) 72	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward Brown			14. MOTHER'S MAIDEN NAME Emma Costill				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Amos F. Groff, 1008 Leeds Avenue 21229		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 250.91 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD = C.H.F. (C) PNEUMONITIS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5:25 20 yrs.	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION 0 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 0		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 0		21C. WHERE DID INJURY OCCUR? 0		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -			
22. I certify that (1) (this hospital) attended the deceased from 10/26 19 71 to 10/27 19 71 that (1) (we) last saw the deceased alive on 10/26 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ted Wingard, M.D.				23B. DATE SIGNED 10/27/71		23C. PHYSICIAN'S NAME (Type) Ted Wingard, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-29-71		24C. NAME OF CEMETERY or CREMATORY Belair Memorial Gardens		24D. LOCATION (City, town, or county) (State) Belair, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 10041	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. L-525		71 10041			
1. NAME OF DECEASED (Type or Print) G. Guy Longan			2. DATE AND HOUR OF DEATH 10-26-71 9:35 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital, Inc. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2541		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 808 St. Paul St.		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-22-1903	9. AGE (In years last birthday) 68	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bricklayer			11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME A. William Longan			14. MOTHER'S MAIDEN NAME Helen Miller Longan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-07-3960 A		17. INFORMANT Mrs. Helen E. German, 2713 Brinkleigh Dr. ADDRESS 21043
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 313X1 Peritonitis.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH a day		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Malnutrition & fecal impaction a week (C) lung abscess. (A/T.B) ?					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 25 1971 to Dec 26 1971 that (I) (we) last saw the deceased alive on Oct 26 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John Obe			23B. DATE SIGNED Oct. 26, 71		23C. PHYSICIAN'S NAME (Type) Tshru ONE
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 10-29-71		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971			25B. NAME OF REGISTRAR E. J. Jaber, R.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229
24D. LOCATION (City, town, or county) Baltimore, Maryland			24E. ADDRESS 21229		

401 Yale Ave.
5/6/68 - Adm.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

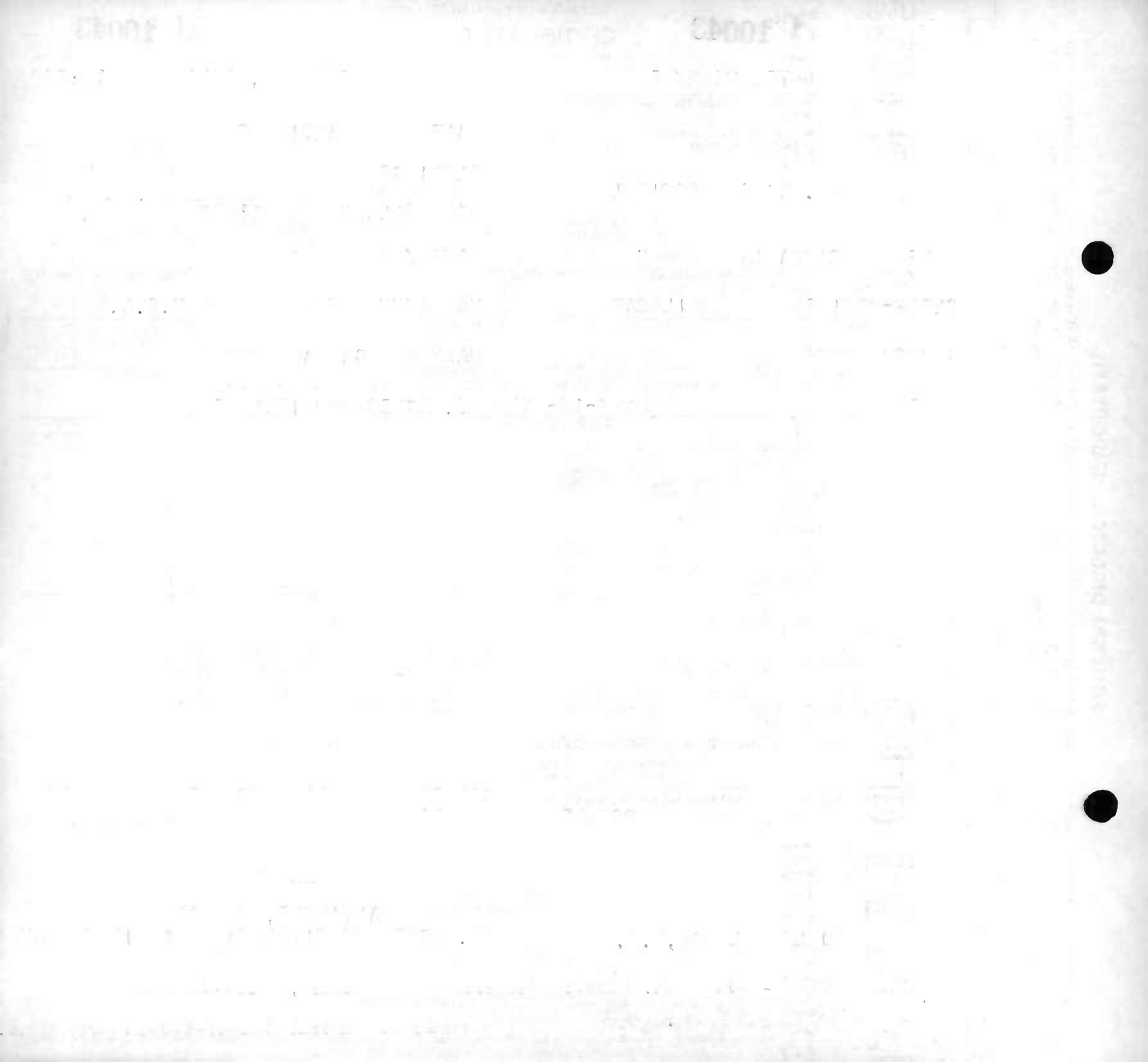
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 10042</u>	
S-420 71 10042				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>SALKO, ANDREW</u>		2. DATE AND HOUR OF DEATH <u>10/27/71</u> <u>6:00 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u>	
				C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>5134 WRIGHT AVE</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-17</u>	9. AGE (In years last birthday) <u>54</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Patterson Park High School</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>SALKO, ANDREW C.</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA Ohazzo</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes WW II</u>	
16. SOCIAL SECURITY NO. <u>197-07-7778</u>				17. INFORMANT <u>Helen Salko (wife) same address</u>	
18. <u>430.91</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Ruptured Berry Aneurysm</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>Oct 17</u> 19 <u>71</u> to <u>Oct 27</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>Oct 27</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Nicholas A. Volpicelli M.D.</u>				23B. DATE SIGNED <u>Oct 27, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>NICHOLAS VOLPICELLI, M.D.</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/30/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 1 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Schumnek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213</u>			

10013

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> 7-300 71 10043 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <u>71 10043</u>	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) FOOTE, HENRY E		2. DATE AND HOUR OF DEATH OCTOBER 28, 1971 12:55P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 2em; margin-left: 10px;">40</div> ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MALE BALTIMORE C. CITY OR TOWN ELKRIDGE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5833 Bellanca Dr. Elkridge XXXXXXXXXXXXXXXXXXXX Md.	
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03/18/88
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK-RETIRED		10B. KIND OF BUSINESS OR INDUSTRY RAILROAD	9. AGE (in years last birthday) 83 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH FOOTE		14. MOTHER'S MAIDEN NAME MARY ANN GADDARD FOOTE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 705-16-6740	
17. INFORMANT Barbara Fitzgerald - Same ADDRESS _____		18. CAUSE OF DEATH ST. AGNES HOSPITAL RECORDS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Dissecting Aneurysm		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: _____ (B) DUE TO, OR AS A CONSEQUENCE OF: _____ (C) _____	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Dissecting Aneurysm		22. I certify that (I) (this hospital) attended the deceased from OCTOBER 14 1971 to OCTOBER 28 1971 that (I) (we) last saw the deceased alive on OCTOBER 28 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <i>Adolfo Alonso</i> 23C. PHYSICIAN'S NAME (Type) ADOLFO ALONSO, M.D.		23B. DATE SIGNED _____ Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-1-71	
24C. NAME of CEMETERY or CREMATORY St. Patrick Cemetery		24D. LOCATION (City, town, or county) (State) Natrick, Massachusetts	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971		25B. NAME OF REGISTRAR Robert E. Wilkins, M.D.	
25C. FUNERAL DIRECTOR Armacost Funeral Chapel-4600 Liberty Hgts.		ADDRESS _____	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 10044</u>	
17-425 71 10044		71 10044		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MULLIKIN GEORGE E		28 Oct. 71 12:35 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
		MARYLAND		2841	
42 SINAI Hospital		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		5328 Liberty Hghts. Ave #7			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
MALE	C N	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/13/90	81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Sales MANAGER				Baltimore, Md	
12. FATHER'S NAME		13. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
George B. Rush		CROGGIN		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No -		Yes -		Arthur M. Hubbard-	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		cardiac Arrhythmia			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(C) DUE TO, OR AS A CONSEQUENCE OF:			
		Chc. destructive lung disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
		Degenerative heart disease			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/16</u> 19 <u>71</u> to <u>10/28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Chalempidil Thananopavarn MD</u>				23B. DATE SIGNED <u>Oct. 28 - 71</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHALEMPIDIL THANANOPAVARN MD</u>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		10-30-71		Loudon Park Cemetery	
				BALTIMORE, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 1 1971		Robert E. Taylor, R.D.		Armacost Funeral Chapel - 400 Liberty Hghts	

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George, Ross

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FUNERAL DIRECTOR: IMPORTANT

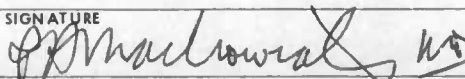
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
REG. NO. 71 10045									
BIRTH NO. 4-155		1. NAME OF DECEASED (Type or Print) William R. Hoffman				2. DATE AND HOUR OF DEATH October 28, 1971 8 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3901 2nd Street Baltimore, Md 21225						A. STATE Maryland		B. COUNTY 7 2534	
						C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						E. STREET AND NUMBER 3901 2nd Street			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/11/01		9. AGE (In years last birthday) 70		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Glazier				10B. KIND OF BUSINESS OR INDUSTRY Pittsburgh Plate Glass Company		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Ernest Hoffman						14. MOTHER'S MAIDEN NAME Emma Lang			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212 10 8786		17. INFORMANT ADDRESS 202 E. Jeffrey St. Mrs Virginia Mazure Balto, Md 21225			
18. 4/10/71 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) myocardial infarction						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. arteriosclerosis						(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Jan 19 51 to Oct. 15 1971 , that (I) (was) last saw the deceased alive on Oct. 15 19 71 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.									
23A. SIGNATURE Eugene Schnitzer						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10-29-71	
23C. PHYSICIAN'S NAME (Type) Eugene Schnitzer M.D.						23D. ADDRESS 3904 S. Hanover St. Balto, Md 21225			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/1/71		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore 21225 Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971		25B. NAME OF REGISTRAR Robert E. Gonce, M.D.		25C. FUNERAL DIRECTOR George J. Gonce		25D. ADDRESS 4001 Ritchie Hwy Baltimore, Md 21225			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10046	
K-526 71 10046				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) KINCER, RUFUS STEEL			2. DATE AND HOUR OF DEATH 10/28/71 12:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2544		
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD, BALTIMORE, MARYLAND 21218			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 935 MAYADON COURT		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/5/31	9. AGE (In years last birthday) 40	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Security Guard		10B. KIND OF BUSINESS OR INDUSTRY Detective Agency		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME RAY KINCER		
14. MOTHER'S MAIDEN NAME GLADYS MINNIE Monahan			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 3/1/51 TO 2/22/54		
16. SOCIAL SECURITY NO. 214-26-5638			17. INFORMANT ADDRESS MEDICAL RECORDS AT V.A. HOSPITAL, 3900 LOCH RAVEN BLVD., BALTIMORE, MD. 21218		
18. 571.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) LAENNEC'S CIRRHOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC ALCOHOLISM			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). OLD MYOCARDIAL INFARCTION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/19 19 71 to 10/28/71 19 71 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/28 19 71 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) XXXX view the body after death.					
23A. SIGNATURE  DEGREE			23B. DATE SIGNED 10/28/71		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) P.A. MACKOWIAK, M.D.			23D. ADDRESS V.A. HOSPITAL, 3900 LOCH RAVEN BLVD., BALTIMORE, MARYLAND 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/1/71		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore 21225 Md		25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971			
25B. NAME OF REGISTRAR John E. Jaber, R.D.		25C. FUNERAL DIRECTOR George J. Gonce			
25D. ADDRESS 4001 Ritchie Hwy Baltimore, Md 21225					

Monahan

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FUNERAL DIRECTOR: IMPORTANT

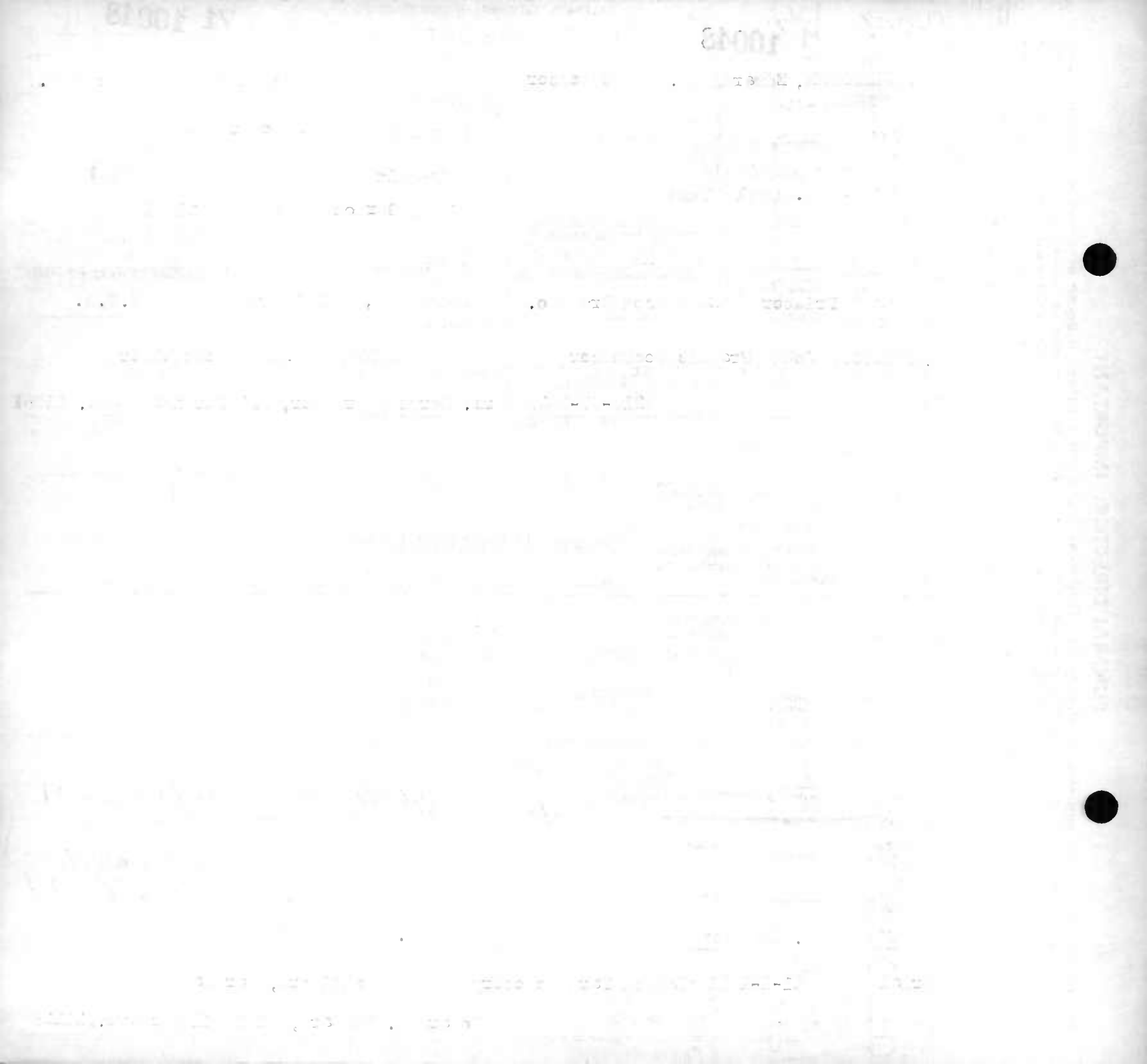
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-432 71 10047		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 10047	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) SHULTZ, SR. ROBERT IRVIN		2. DATE AND HOUR OF DEATH OCTOBER 28, 1971 1 7:00A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND		B. COUNTY 2047	
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL 40		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 7 S MONASTERY AVENUE		21229	
5. SEX MALE	6. RACE CAUCASIAN WXXX	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08 17 95	9. AGE (In years last birthday) 76	10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10B. KIND OF BUSINESS OR INDUSTRY William Dawson		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Hezekiah Shultz XXXX PETER X SHULTZ X		14. MOTHER'S MAIDEN NAME (BURNS) LENORE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW-2 1		16. SOCIAL SECURITY NO. 216-07-8468		17. INFORMANT RECORD'S BALTIMORE ID 21229 ST AGNES HOSPITAL WILKENS & CATON AVE	
18. 199.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Transitional cell DUE TO, OR AS A CONSEQUENCE OF: Carcinoma with metastases (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Hydronephrosis @ Kidney		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 17, 19 71 to OCTOBER 28, 19 71 that (X) (we) last saw the deceased alive on OCTOBER 28, 19 71 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE Adolfo Alonso M.D.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) ADOLFO ALONSO, M.D.	
23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE		23E. DEGREE DEGREE		23F. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-1-71		24C. NAME OF CEMETERY OR CREMATORY Western Cemetery	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, town, or county)		24F. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 10048</u>	
BIRTH NO. <u>W-226 71 10048</u>				1. NAME OF DECEASED (Type or Print) <u>Weckesser, Edward C.</u>		2. DATE AND HOUR OF DEATH <u>10/28/71 7:03</u> <u>7:03 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>37 301 St. Paul Place</u> <u>Mercy Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel</u> C. CITY OR TOWN <u>Glen Burnie</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>1421 Gordon Drive</u> <u>21061</u>			
5. SEX <u>M</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/26/99</u>		9. AGE (In years last birthday) <u>72</u>	10. Under 1 Yr. Months: Days: Hours: Min. <u>10/28/71</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Printer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Edmondson Drug Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland, Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>XXXXXXXXXX John Francis Weckesser</u>				14. MOTHER'S MAIDEN NAME <u>XXXXXXXXXX Anna Heatfelder</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-7429</u>		17. INFORMANT ADDRESS <u>Mrs. Dorothy Drenner, 352 Ferdinand Ave. 21061</u>			
18. <u>441.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>RUPTURED AORTIC ANEURYSM</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>PANCREATITIS</u> <u>ASCVD</u> <u>ALS</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>D</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. (IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF (INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>301 St. Paul Place</u>		21C. WHERE DID (INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. (INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID (INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10/28</u> 19 <u>71</u> to <u>10/28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Thomas G. Brennan</u>				23B. DATE SIGNED <u>10/28/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Thomas G. Brennan</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-1-1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 1 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>		25D. ADDRESS <u>4107 Wilkens Ave. 21229</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>71 10049</u>	
BIRTH NO. <u>D-220</u>		71 10049			
1. NAME OF DECEASED (Type or Print) <u>DICUS, EDGAR HOWARD</u>			2. DATE AND HOUR OF DEATH <u>OCTOBER 30, 1971</u> <u>1:40 A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST AGNES HOSPITAL</u>			C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
			E. STREET AND NUMBER <u>27 S. PROSPECT AVENUE 21228</u>		
5. SEX <u>MALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03/24/07</u>	9. AGE (In years last birthday) <u>64</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>ARTHUR DICUS</u>		14. MOTHER'S MAIDEN NAME <u>MAGGIE KING</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-07-3560</u>		17. INFORMANT <u>CATON AVES., BALTO., MD. 21229</u> <u>ST AGNES HOSPITAL RECORDS, WILKENS &</u>	
18. <u>436.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>C.V.A.</u>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>± 5 days</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <u>hypertension</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>2 years.</u>
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>D</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>OCTOBER 26, 1971</u> to <u>OCTOBER 30, 1971</u> that (X) (we) last saw the deceased alive on <u>OCTOBER 30, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J.J. Mol.</u>			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10/30.</u>
23C. PHYSICIAN'S NAME (Type) <u>J.J. MOL, M.D.</u>			23D. ADDRESS <u>BALTO MD 21229</u> <u>ST AGNES HOSPITAL WILKENS & CATON AVES.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-2-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 1 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	

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Sheet 2

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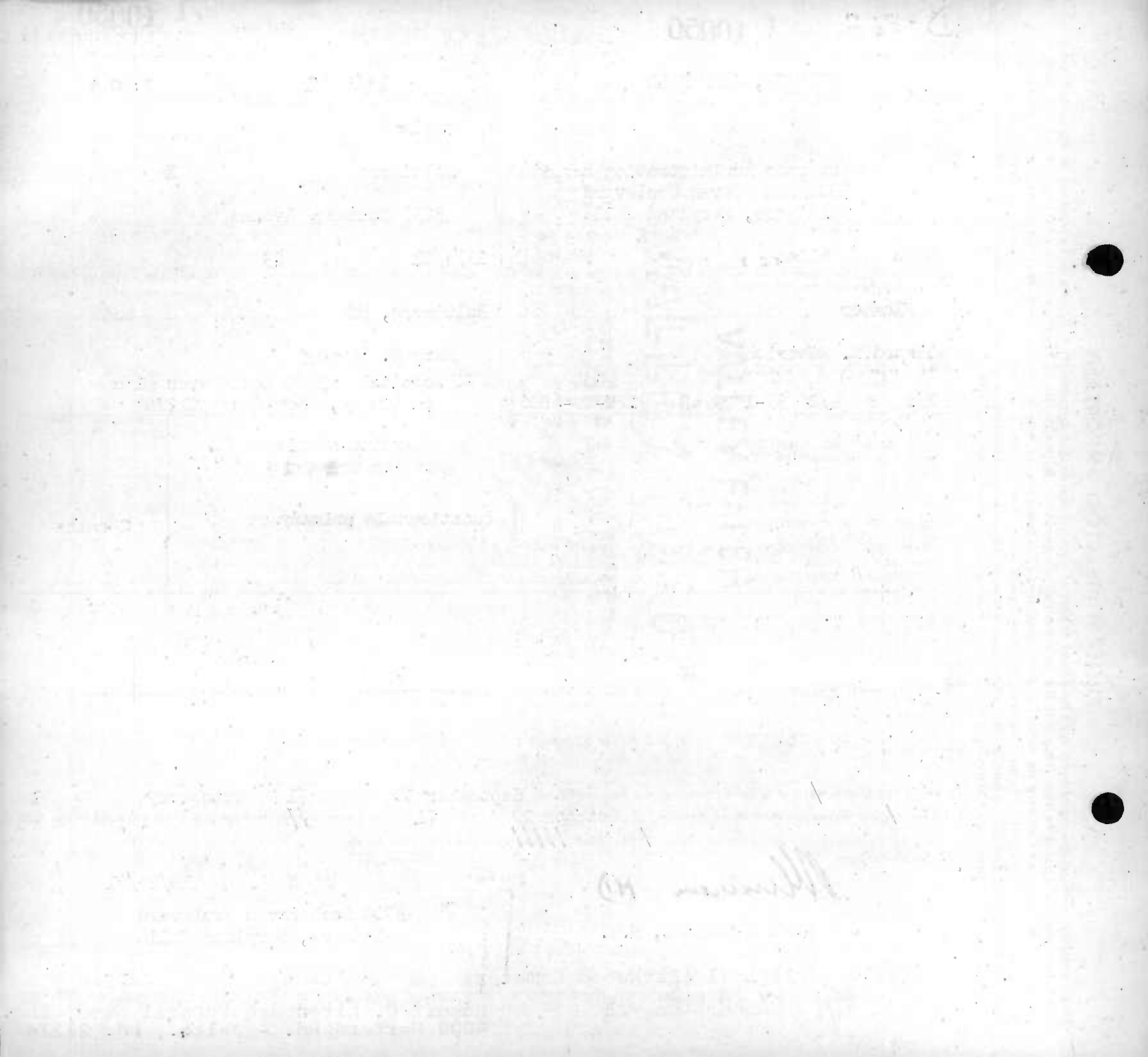
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-362 71 10050				BALTIMORE CITY HEALTH DEPARTMENT		71 10050	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
DIETRICH, JOHN HALL				10/29/71		2:00 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				Maryland		2633	
5. SEX				6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH				9. AGE (In years last birthday)		10. UNDER 1 Tr. Months Days	
11/4/21				49			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Baltimore, Md				USA			
13. FATHER'S NAME				14. MOTHER'S MARDEN NAME			
Richard R. Dietrich				Mary E. Murphy			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes 4/26/39-1/29/42				220-09-6206		VA Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218	
18. 199.0 I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Carcinomatosis			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				questionable primary			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
II				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				20A. AUTOPSY? (Yes or No)			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 30 19 71 to October 29 19 71, that (I) (we) last saw the deceased alive on October 29 19 71, and that (I) (we) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE			
23B. DATE SIGNED				23C. PHYSICIAN'S NAME (Type)			
10/29/71				NOEL GRESSIEUX, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial				11/1/71		Parkwood Cemetery	
24D. LOCATION				24E. LOCATION			
Baltimore				Maryland			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 1 1971				Robert C. Altenburg		6009 Harford Rd. - Balto., Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
REG. NO. <u>71 10051</u>									
U-323 71 10051									
BIRTH NO.									
1. NAME OF DECEASED (Julius Frank Wittstruck) (Type or Print) <u>WITTSTRUCK FRANK J.</u>					2. DATE AND HOUR OF DEATH <u>10/27/71. 2 12-30 P.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>212142745</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CHURCH HOMES HOSPITAL</u>					C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER <u>3020 ROSE LAWN AVE.</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>07-04-99</u>	9. AGE (In years last birthday) <u>72 y</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRESS MAN</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>PRINTING PRESS</u>		11. BIRTHPLACE (State or foreign country) <u>NEBRASKA</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>		
13. FATHER'S NAME <u>MUSE H WITTSTRUCK</u>					14. MOTHER'S MAIDEN NAME <u>MATILDA HARMS</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>215-09-7986</u>		17. INFORMANT <u>D. MENA CHH BALTO</u>				
18. <u>157191</u> CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ANTCEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					(A) IMMEDIATE CAUSE <u>METASTATIC DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CA OF STOMACH.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				
19A. DATE OF OPERATION <u>10-12-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA STOMACH</u>			20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____					
22. I certify that (I) (this hospital) attended the deceased from <u>10/5/71</u> 19 <u>71</u> to <u>10/27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/27</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Ashwin Mehta</u>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>10/27/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR ASHWIN MEHTA</u>					23D. ADDRESS <u>CHURCH HOMES HOSP, BALTO MD-21231</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/30/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 1 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Robert C. Altenburg Funeral Home, Inc.</u> 6009 Harford Rd. - Balto., Md. 21214					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 10052	
BIRTH NO. S-346 71 10052				1. NAME OF DECEASED (Type or Print) STAYLOR, MARION A			
2. DATE AND HOUR OF DEATH				OCTOBER 27, 1971 11:30A.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE MARYLAND B. COUNTY BALTIMORE			
40 ST. AGNES HOSPITAL				C. CITY OR TOWN HALETHORPE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER				5718 FIRST AVE 21227			
5. SEX MALE		6. RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 06/06/96	
9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR-RETIRED		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. KIND OF BUSINESS OR INDUSTRY SAVINGS BANK				13. FATHER'S NAME AND GUARD WALTER STAYLOR			
14. MOTHER'S MAIDEN NAME SADIE (BELL)				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE			
16. SOCIAL SECURITY NO. 217-09-4234				17. INFORMANT Mrs. Ruth Staylor, 5718 First Avenue 21227 ST. AGNES HOSPITAL RECORDS			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial infarction			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Arteriosclerotic heart disease indef.			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NONE		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 27 19 71 to OCTOBER 27 19 71 that (I) (we) last saw the deceased alive on OCTOBER 27 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED 10/27/71		23C. PHYSICIAN'S NAME (Typed) WESTPHALEN, M.D.	
23D. ADDRESS BALTIMORE, MARYLAND 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVE				23E. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-30-1971		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	

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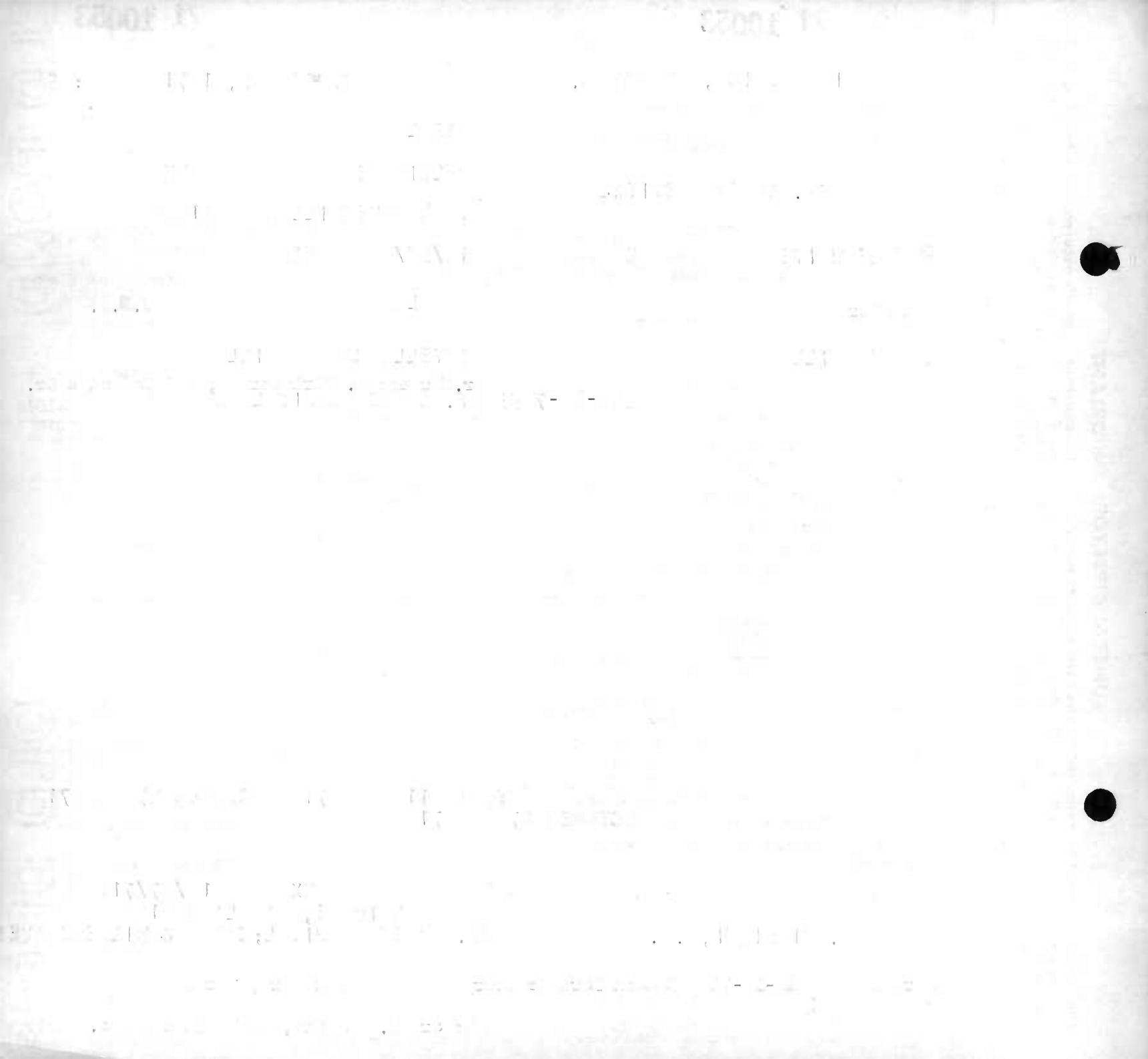
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

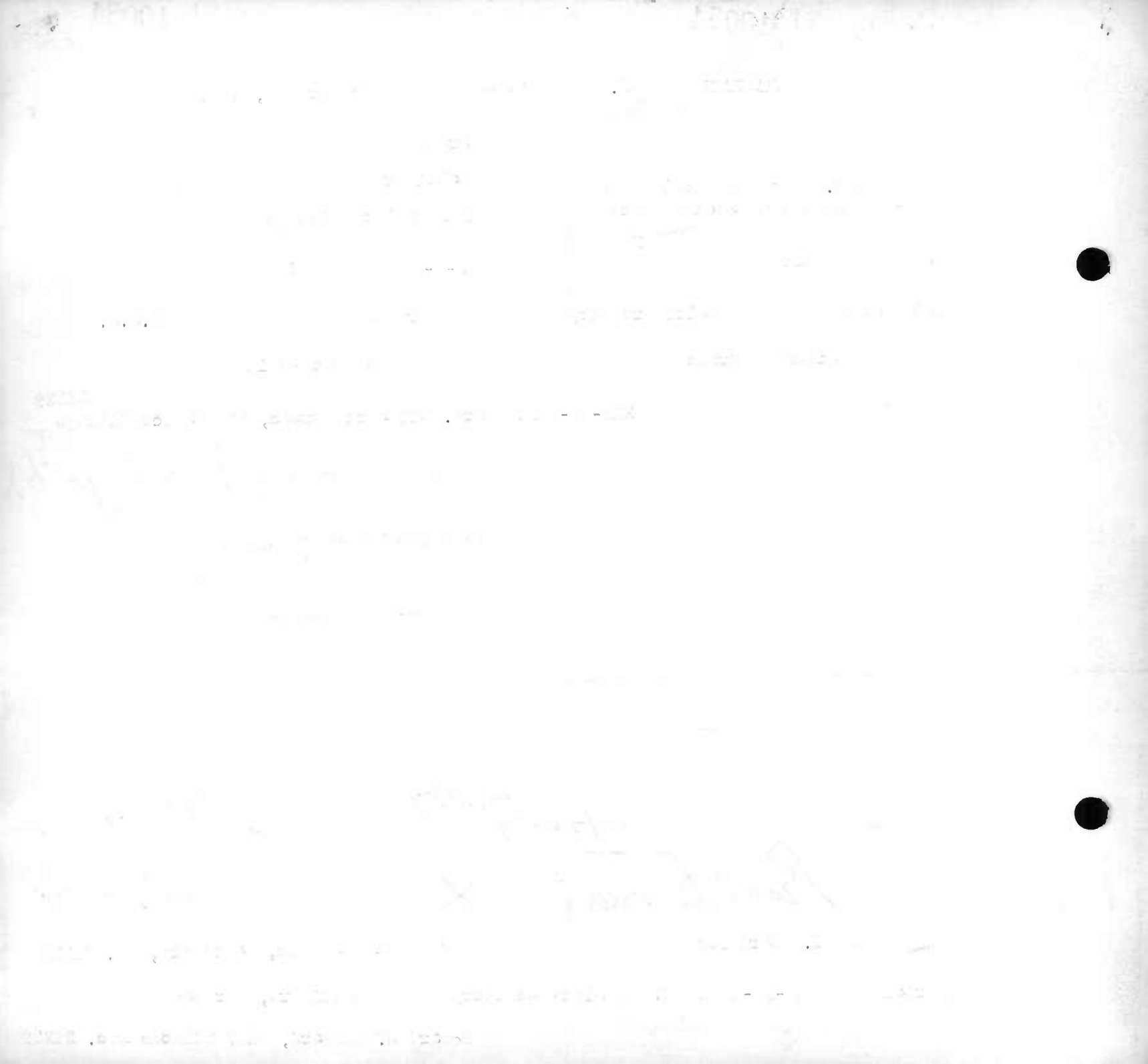
BALTIMORE CITY HEALTH DEPARTMENT				71 10053	
K-621 71 10053				REG. NO.	
BIRTH NO.				71 10053	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
KIRKPATRICK, BERTHA E.				OCTOBER 27, 1971 6:45A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
40 ST. AGNES HOSPITAL				MARYLAND 2551	
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
FEMALE WHITE				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. DATE OF BIRTH 9. AGE (In years last birthday)				E. STREET AND NUMBER	
12/25/88 82				1004 HAVERHILL RD 21229	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
Homemaker				MARYLAND	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				U.S.A.	
STEPHEN HILL				14. MOTHER'S MAIDEN NAME	
ESTELLA CANNON HILL				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
No				16. SOCIAL SECURITY NO.	
220-48-7253				17. INFORMANT	
Mr. Ernest B. Kirkpatrick, 301 Lakeside Dr.				ST. AGNES HOSPITAL RECORDS 21014	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				Acute Pulmonary Oedema	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				acute ASCVD	
(C) Renal Disease with Uræmia				II	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				19A. DATE OF OPERATION	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				NONE	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 11 1971 to OCTOBER 27 1971 that (I) (we) last saw the deceased alive on OCTOBER 27 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
M. Yousuf Siddiqui				10/27/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Y. SIDDIQUI, M.D.				BALTIMORE, MARYLAND 21229	
24A. SURIAL CREMATION, REMOVAL (Specify)				24B. DATE	
Burial				10-30-71	
24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
Loudon Park Cemetery				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR	
NOV 1 1971				25C. FUNERAL DIRECTOR	
Howard H. Hubbard, 4107 Wilkens Ave. 21229				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				71 10054 REG. NO.	
BIRTH NO. 1		G-620 71 10054			
1. NAME OF DECEASED (Type or Print) STANTON J. GRACE			2. DATE AND HOUR OF DEATH October 26, 1971		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital Wilkins & Caton Avenues			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2551 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 373 Oaklee Village		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-6-1909	9. AGE (In years lost birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10B. KIND OF BUSINESS OR INDUSTRY Baltimore City	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Grace			14. MOTHER'S MAIDEN NAME Minnie Sedicum		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-46-9456	17. INFORMANT ADDRESS Mrs. Elizabeth Grace, 373 Oaklee Village 21229		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? A. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Hemorrhage B. DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Lung C. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?					
MEDICAL CERTIFICATION 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 5/12/71 to 10/26/71 that (I) (we) last saw the deceased alive on 10/26/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above: (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE 23B. DATE SIGNED 23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS 24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State) 25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS					
I. Earl Pass			4001 Wilkins Avenue, Baltimore, Md. 21229		
Burial		10-30-1971	Loudon Park Cemetery		Baltimore, Maryland
NOV 1 1971		Robert E. Taylor, M.D.	Howard H. Hubbard, 4107 Wilkins Ave. 21229		



FUNERAL DIRECTOR: IMPORTANT

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<div style="display: flex; justify-content: space-between;"> V-525 71 10055 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <u>71 10055</u>	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) <u>Elizabeth P. Vincent</u>		2. DATE AND HOUR OF DEATH <u>10-29-71</u> <u>6 a.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1276 Meridene Drive</u>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2738</u>	
5. SEX <u>F</u>		6. RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-7-20</u>	
9. AGE (in years last birthday) <u>51</u>		10. If Under 1 Yr. Months: _____ Days: _____ 11. If Under 24 Hrs. Hours: _____ Mins: _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert W. Dixon Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Kahoe</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-12-9052</u>	
17. INFORMANT <u>Carlos L. Vincent, husband, 1276 Meridene Dr.</u>		ADDRESS <u>1276 Meridene Dr.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>UREMIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>URETERAL OBSTRUCTION</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>1 month</u>	
(C) <u>CARCINOMA OF CERVIX</u>		<u>2 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>NO</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>NO</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7</u> <u>19 70</u> to <u>10</u> <u>19 71</u> that (I) (we) last saw the deceased alive on <u>20 Oct 19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Edward M. Barczak</u>		23B. DATE SIGNED <u>10/29/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Edward M. Barczak</u>		23D. ADDRESS <u>2 E. Read St.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-1-71</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Dulaney Valley Mem. Grds.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore County, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 1 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Faby, R.D.</u>	
25C. FUNERAL DIRECTOR <u>H.W. Jenkins Sons Co.</u>		ADDRESS <u>4905 York Rd. Baltimore, Md. 21212</u>	

11/5/71 - Correction form from funeral director.

APC.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. 71 10056	
BIRTH NO. S-160		71 10056		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Alice Mae Shaffer		October 31, 1971		4:05 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 104 W. University Pkwy.				A. STATE Md.		B. COUNTY 1201	
				C. CITY OR TOWN Baltimore		D. (INSIDE CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 104 W. University Pkwy.							
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-5-1879	9. AGE (In years last birthday) 91	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Wilson				14. MOTHER'S MAIDEN NAME Josephine Taylor			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT G. Wilson Shaffer 3409 Greenway			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of Colon</i>		6 mo	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Hypertension ASCVD				10 yrs			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/15/55 to 10/31/71 that (I) (we) lost saw the deceased alive on 10/29/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Francis W. Gluck</i>				23B. DATE SIGNED 11/1/71		23C. PHYSICIAN'S NAME (Type) Dr. Francis W. Gluck	
23D. ADDRESS 100 W. University Pkwy.		23E. DEGREE		23F. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 11-2-71		24C. NAME OF CEMETERY or CREMATORY Greenmount Crematory		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212			

ca. 1800

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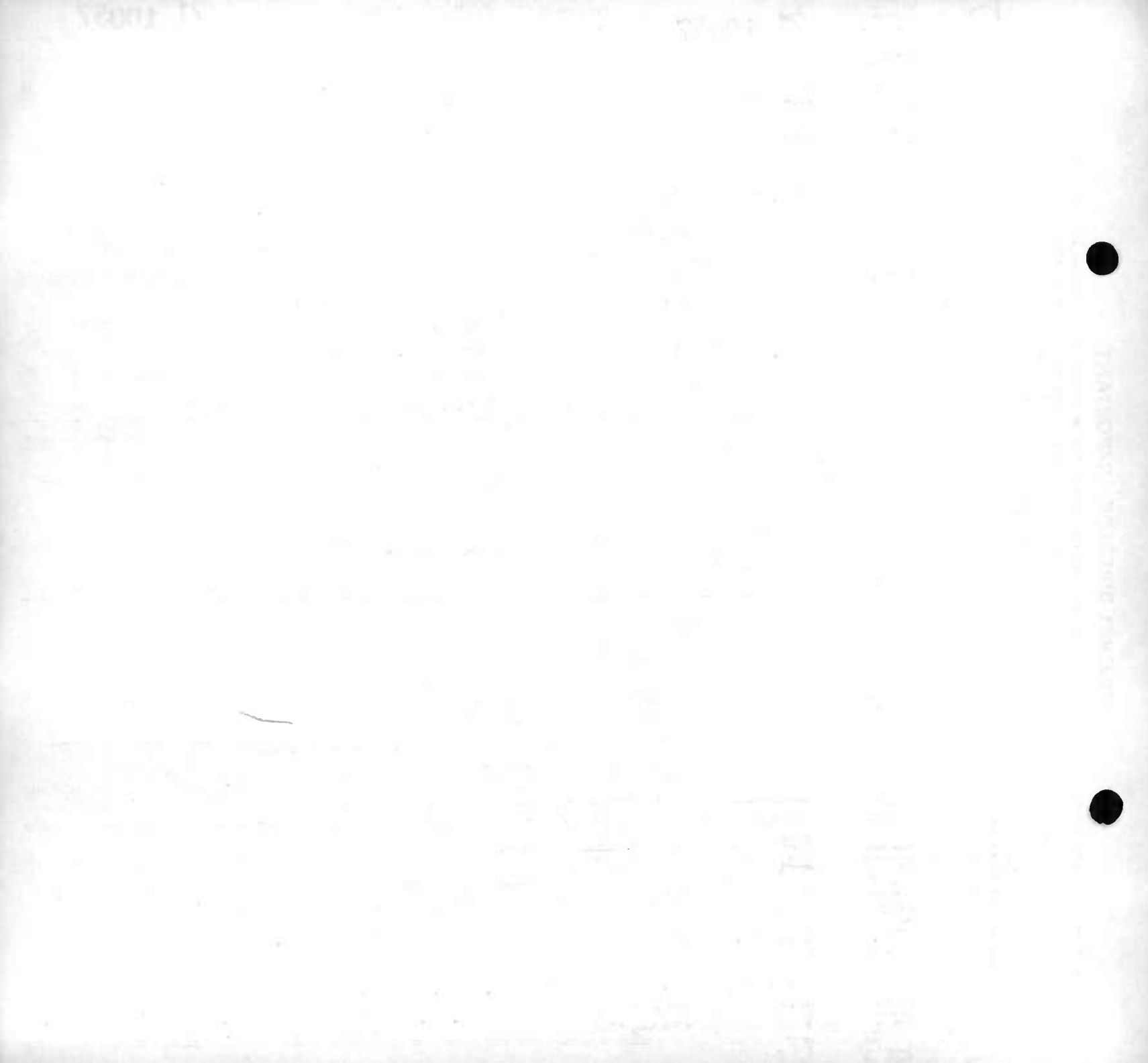
1800

1800

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

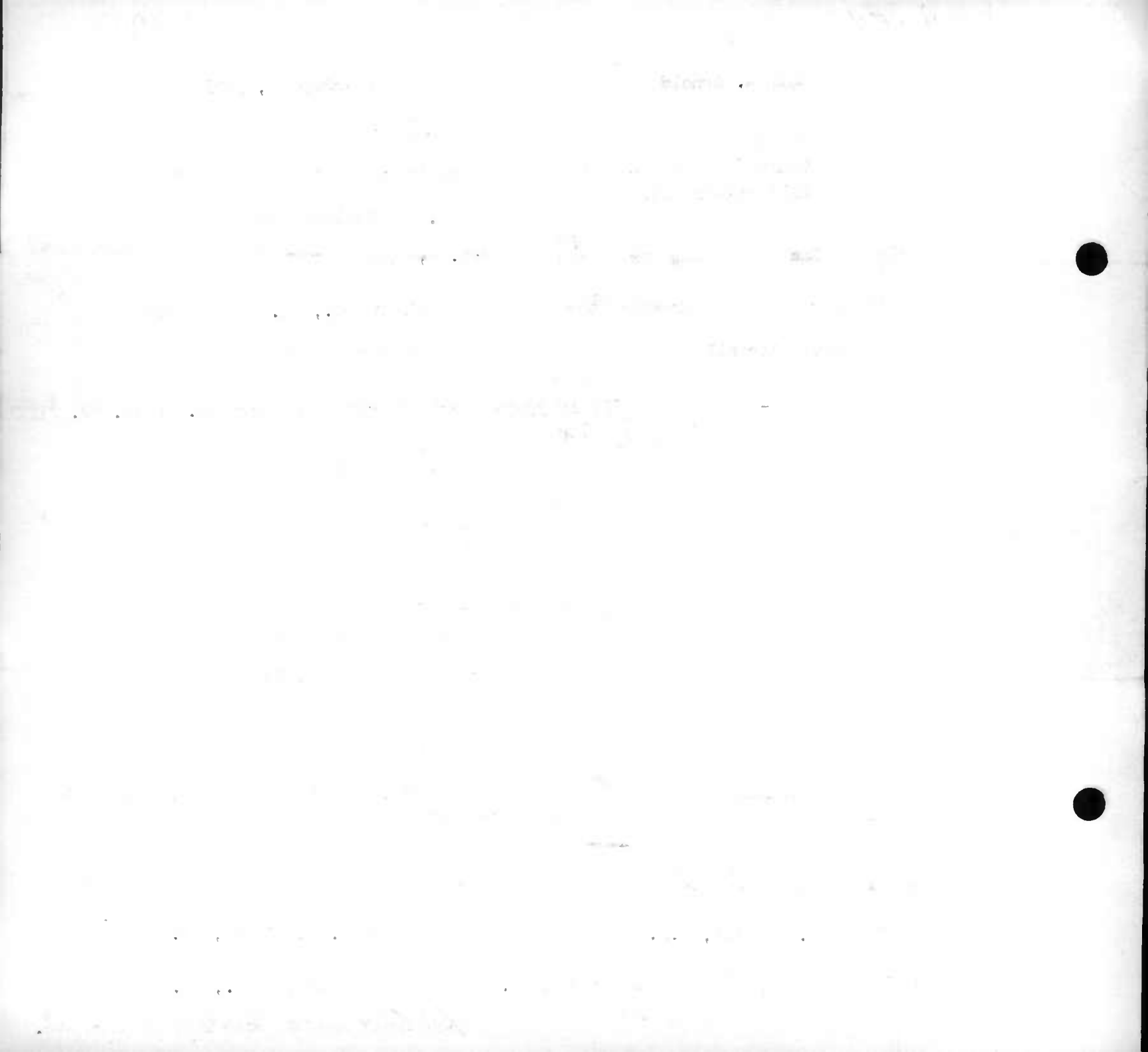
BALTIMORE CITY HEALTH DEPARTMENT				71 10057	
S-616 71 10057				CERTIFICATE OF DEATH	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Florence May Scarborough			Oct. 31, 1971 2 ⁰⁰ A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
90 Long Green Nursing Home			Md.		
5. SEX			6. DATE OF BIRTH		9. AGE (In years last birthday)
F			5-18-1893		78
7. RACE			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		10. AGE (In years last birthday)
W			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife			Own Home		Baltimore, Maryland
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William D. Norris			Anna M. Huster		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
no			213-52-6506		Mr Lester Guy Scarborough Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from			1965 to Oct 31 1971		
that (1) (we) last saw the deceased alive on			Oct 27 1971 and that in (my) (our) opinion death occurred on the date		
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
23A. SIGNATURE			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Dr. William G. Helfrich			5006 Roland Ave.		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY
Burial			11-2-71		Ascension Episc. Ch. Cem. Dublin, Md.
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
NOV 1 1971			Robert E. Jarboe, M.D.		H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		71 10058		REG. NO. 71 10058	
BIRTH NO. A-654		71 10058		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		Ruth A. Arnold		2. DATE AND HOUR OF DEATH October 27, 1971 10:5 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION 90		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Gould onvalescent Home 6116 Belair Road		C. CITY OR TOWN Baltimore 21224	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 224 S. Highland Avenue	
5. SEX Female	6. RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1895	9. AGE (in years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fountain Clerk		10B. KIND OF BUSINESS OR INDUSTRY Kressge Store		11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Mitchell		14. MOTHER'S MAIDEN NAME Elizabeth Harris	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219 10 3395A		17. INFORMANT Doris Volz 544 Sue Grove Rd. Balto. Md. 21221	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Anterior wall Heart Dissection</i> (B) <i>Generalized Anterior wall</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Multiple "hole" strokes; Cerebral Arteriosclerosis; Chronic Vascular Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/21/71</u> to <u>10/27/71</u> that (I) (we) last saw the deceased alive on <u>10/27/71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <i>Albert B. Bradley</i>		23B. DATE SIGNED 10/29/71		23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D.	
23D. ADDRESS 4900 Belair Rd. Baltimore, Md.		23E. DATE REC'D BY HEALTH DEPT. NOV 1 1971		23F. NAME OF REGISTRAR Robert E. Fisher, M.D.	
23G. FUNERAL DIRECTOR Brazzinski Funeral Home		23H. ADDRESS 4407 Eastern Ave.		23I. DATE OF BURIAL 10/30/71	
23J. NAME OF CEMETERY OR CREMATORY Ebenezer Meth Ch. Cemetery		23K. LOCATION (City, town, or county) (State) Baltimore Co., Md.		23L. DATE OF BURIAL 10/30/71	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10059	
71 10059				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Anna Walker		10/28/71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 90 General German Aged People's Home--22 S. Athol Avenue				A. STATE Md	
				B. COUNTY	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 22 S. Athol Avenue					
5. SEX female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/13/1883	9. AGE (in years last birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME George H. Hughes				14. MOTHER'S MAIDEN NAME Mary Dimeler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-09-9314		17. INFORMANT 22 S. Athol Avenue General German Aged People's Home	
18. 44091 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Debility caused by DUE TO, OR AS A CONSEQUENCE OF: (B) advanced arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) and senility terminal cardiac arrhythmia	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 19 71 to 28 Oct 19 71 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William J. Bryson M.D.				23B. DATE SIGNED 29 Oct 71	
23C. PHYSICIAN'S NAME (Type) Dr. Wm. J. Bryson				23D. ADDRESS Westview Mall, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11/1/71		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. J. Baker, M.D.		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., 21228	
25D. ADDRESS					

Adm. 10/64.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10060	
W-623 71 10060		CERTIFICATE OF DEATH	
BIRTH NO. 71 10060		2. DATE AND HOUR OF DEATH 10-29-71 11:55 A.M.	
1. NAME OF DECEASED (Type or Print) WRIGHT ELLA		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY 1607	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Huthuran Hospital Maryland, 730, Ashburton Street, Baltimore MD-21216.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER Hilton Nursing Home 3313 Poplar St.	
8. DATE OF BIRTH 1894 9. AGE (in years last birthday) 77 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) unknown 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hilton Nursing Home, 3313 Poplar St.		ADDRESS	
18. 4369 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH C.V.A. (L) Hemiparesis Cerebrovascular Accident (L) Hemiparesis Same as above	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 10-26- 19 71 to 10-29- 19 71 that (1) (we) last saw the deceased alive on 10-29- 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Jason Samuel N.D. DEGREE		23B. DATE SIGNED 10-29-71	
23C. PHYSICIAN'S NAME (Type) JASON SAMUEL N.D. DEGREE		23D. ADDRESS Huthuran Hospital Maryland, 730, Ashburton St., Baltimore MD-21216.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/30/71	
24C. NAME OF CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., 21228		ADDRESS	

IN N.H. over 1yr.

In Crowsville Prior to this
coded to. N.H.

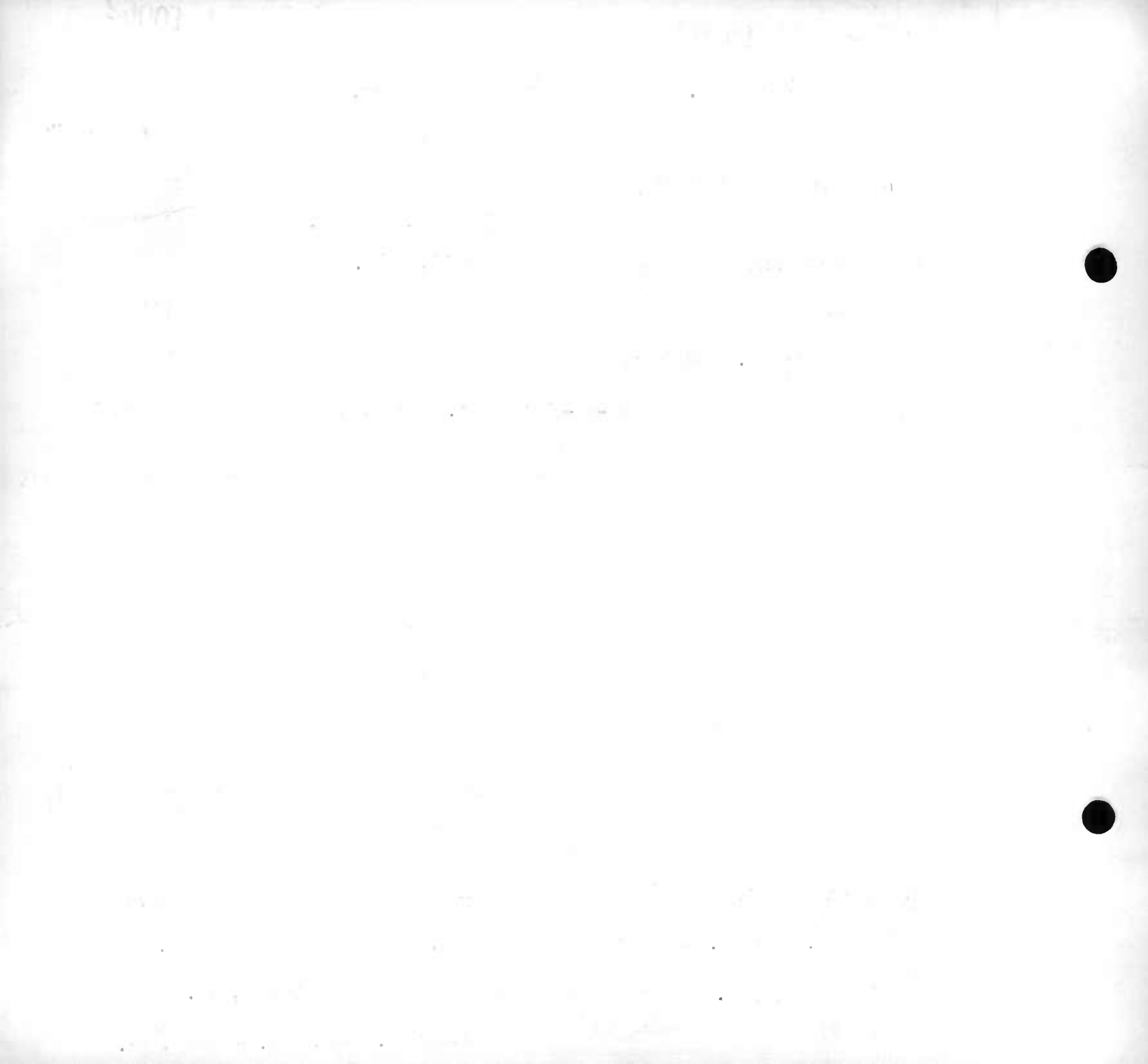
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X CERTIFICATE OF DEATH		REG. NO. 71 10061	
T-625 71 10061		BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
TOROSINO, SARAH CECILIA		OCTOBER 30, 1971		7:00 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
40		ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		MARYLAND HOWARD		21043 6300	
C. CITY OR TOWN		D. INSIDE CITY LIMITS?		E. STREET AND NUMBER			
ELLCOTT CITY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2965 BROOKWOOD ROAD			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
FEMALE		CAUCASIAN		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		06/23/79	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
92		HOUSEWIFE		ITALY		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN DE MARCO				—			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
						BALTO MD 21229	
						ST AGNES' RECORDS CATON & WILKENS AVES	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
412.4 I				Cardiac & Respiratory arrest			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Bilateral Pneumonia			
II				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				ASCUB			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (X) (this hospital) attended the deceased from OCTOBER 29 19 71 to OCTOBER 30 19 71 that (X) (we) last saw the deceased alive on OCTOBER 30 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Sergio San Pedro						10 30 71	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS	
SERGIO SAN PEDRO						CATON & WILKENS AVES. BALTO., MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11/2/71		New Cathedral Cemetery		Baltimore, Maryland 21229	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 2 1971		Robert E. Jarboe, M.D.		Witzke, 1630 Edmondson Ave., 21228			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 10062		BALTIMORE CITY HEALTH DEPARTMENT		71 10062	
BIRTH NO.		71 10062		REG. NO.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
EDNA M. MONROE			Oct. 31, 1971		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL			A. STATE Maryland		
			B. COUNTY 1202		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3019 St. Paul St.		
5. SEX female	6. RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1888.	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John O. Bollinger		14. MOTHER'S MAIDEN NAME Ella Baublitz	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-26-0231		17. INFORMANT Mrs. Lula Hopkins	
				ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YES					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 71 to Oct 71 that (I) (we) last saw the deceased alive on 10/21 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. James J. McPhillips			23B. DATE SIGNED 11/1/71		
23C. PHYSICIAN'S NAME (Type) Dr. James J. McPhillips			23D. ADDRESS 11 E. Chase St, Baltimore, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11/4/71.		Parkwood Cemetery	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
Baltimore, Md.		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Leonard J. Ryck, Inc. - Balto, Md.	



BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		Known <input type="checkbox"/> Month Day Year		Estimated <input type="checkbox"/> M.	
		ROBERT SCHUELER		3. DATE PRONOUNCED DEAD		Month Day Year		Hour	
				10 31 1971		11:20 a.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY					
Union Memorial Hospital				Md. 2744					
6. SEX	7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
12 24 1920		50		Maryland		USA		John Raymond Schueler	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
Baltimore City				Police Dept.		Josephine Schwartz			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS			
NO				215 14 5917		Mrs. Rose Schueler SAME ABOVE			
MEDICAL CERTIFICATION		19. CAUSE OF DEATH							
		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH							
		Ruptured dissecting aneurysm of aorta							
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
		(B) DUE TO, OR AS A CONSEQUENCE OF:							
		11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED						21. AUTOPSY? (Yes or No)	
2								yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)				22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
		ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		Russell S. Fisher, M.D.				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
						DATE SIGNED 11-1-71			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		11 4 71		Holy Redeemer		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
NOV 2 1971		Robert E. Fisher, M.D.		LEONARD J. Ruck, Inc.		BALTO, MD.			

VI 10063

VI 10063

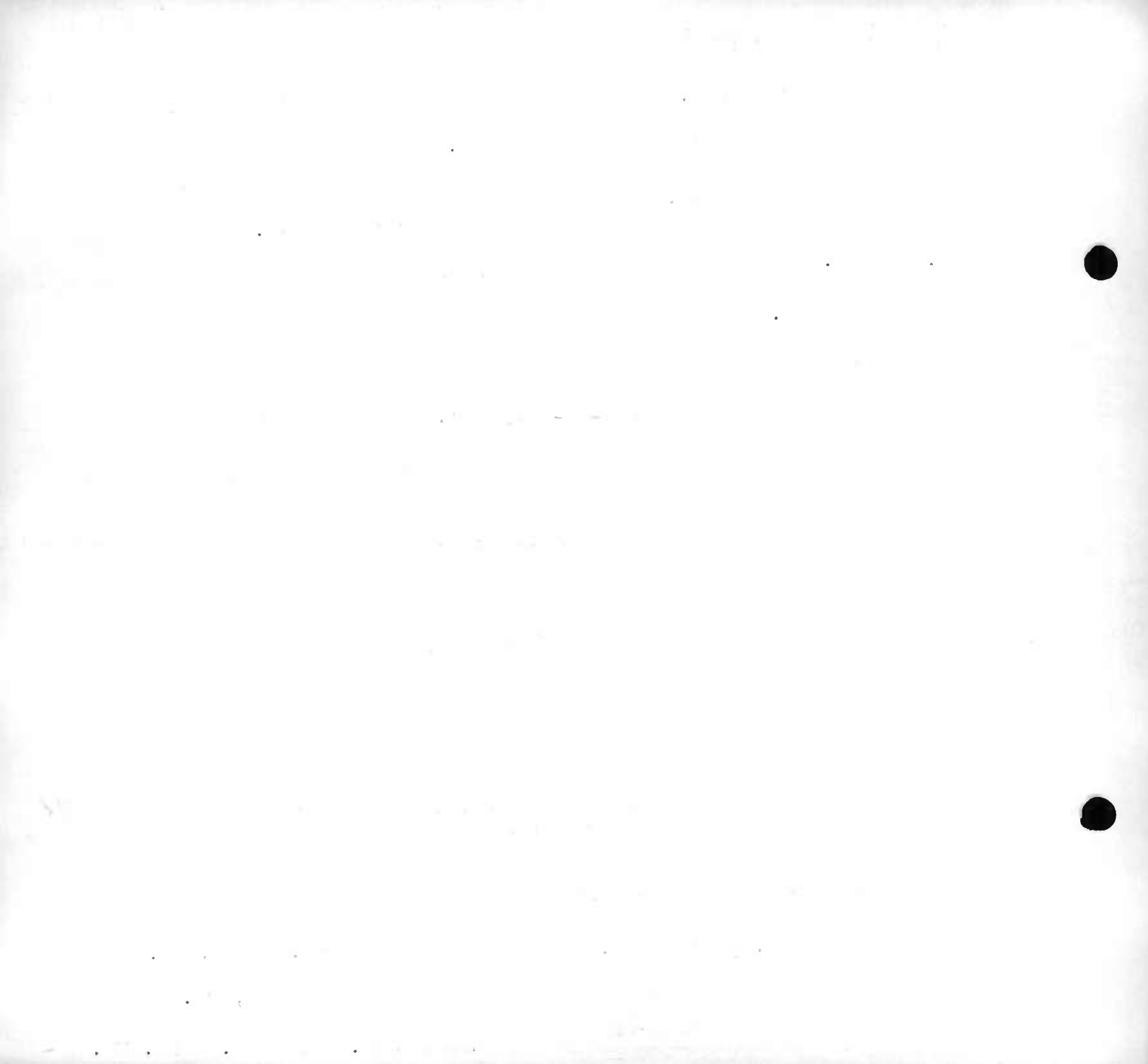
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

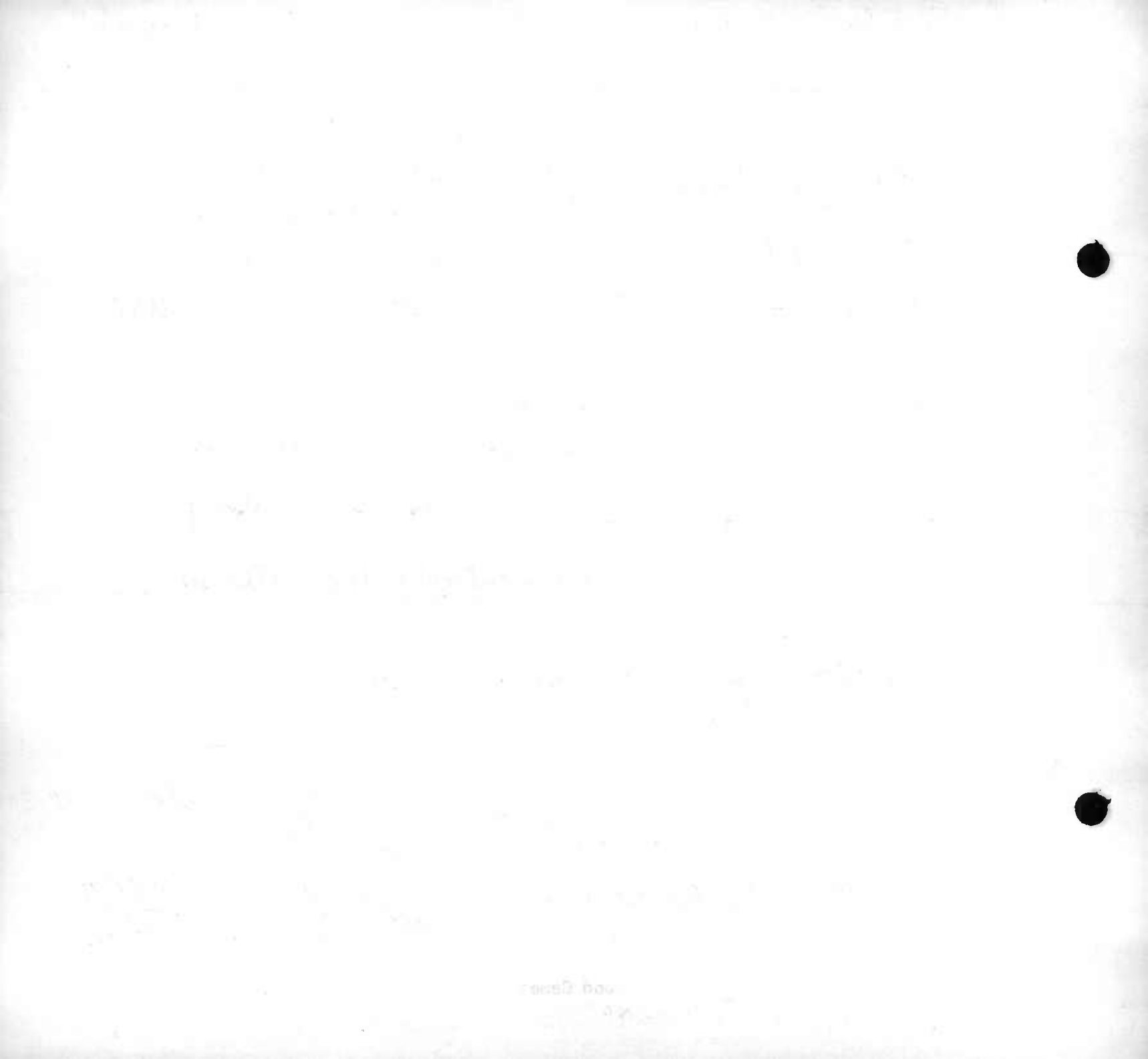
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 10064	
BIRTH NO. K-100			71 10064		
1. NAME OF DECEASED (Type or Print) Friedrich A. Koiv			2. DATE AND HOUR OF DEATH 10/30/71 5⁰⁰ A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION DD 6714 Danville Ave.			A. STATE Md. B. COUNTY 2646		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M.			6. RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor Ret.			8. DATE OF BIRTH 8/28/1882		9. AGE (In years last birthday) 89
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Estonia		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Andrew Koiv			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 214-30-6513		17. INFORMANT Mrs. Helga Sarapik
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few minutes
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Anteriosclerotic cv disease			(B) DUE TO, OR AS A CONSEQUENCE OF: 17 years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Old age					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-21-1954 to 10-30-1971 that (I) (we) last saw the deceased alive on 7-29-1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Paul H. Anniko			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Paul H. Anniko MD.
23D. ADDRESS 3800 Erdman Ave. Balto. Md.			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE NOV 2 1971			24C. NAME OF CEMETERY OR CREMATORY Oaklawn		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. NAME REC'D BY HEALTH DEPT. Robert E. Taylor, R.D.			25B. NAME OF REGISTRAR Leonard J. Oruck, Inc.		25C. FUNERAL DIRECTOR ADDRESS Balto. Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10065</u>	
BIRTH NO. <u>S-534 71 10065</u>		1. NAME OF DECEASED (Type or Print) <u>Swindells, MARTHA E.</u>			
2. DATE AND HOUR OF DEATH <u>10/31/71 3:30 A.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>48 Maryland General Hospital</u>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>2706</u>		5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland General Hospital</u>			
6. CITY OR TOWN <u>Baltimore 2124</u>		7. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
8. STREET AND NUMBER <u>5702 Fair Oaks Ave.</u>		9. SEX <u>F</u> 10. RACE <u>W</u> 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
12. DATE OF BIRTH <u>9/27/83</u>		13. AGE (in years last birthday) <u>88</u>		14. If Under 1 Yr. Months: Days: Hours: Min.	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		16. KIND OF BUSINESS OR INDUSTRY		17. BIRTHPLACE (State or foreign country) <u>Van</u>	
18. CITIZEN OF WHAT COUNTRY? <u>USA</u>		19. FATHER'S NAME <u>William F Whaley</u>		20. MOTHER'S MAIDEN NAME <u>Orra V Palmer</u>	
21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		22. SOCIAL SECURITY NO. <u>214-14-4310</u>		23. INFORMANT ADDRESS <u>Miss Elsie Swindells Same Above</u>	
24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Infarction entire small bowel + half of colon</u>		25. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>superior mesenteric artery occlusion</u>		26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
27. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalized arteriosclerosis</u>		28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
29. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>10/31/71</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>superior mesenteric artery occlusion</u> 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>10/30</u> 19 <u>71</u> to <u>10/31</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/31</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Kator J. Rogosa, M.D.</u> 23C. PHYSICIAN'S NAME (Type) <u>Kator J. Rogosa, M.D.</u>		23B. DATE SIGNED <u>10/31/71</u> 23D. ADDRESS <u>Maryland General Hospital</u>		23E. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11 4 71</u>		24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u>	
24D. LOCATION <u>Baltimore, Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc</u>			
25D. ADDRESS <u>Baltimore, Md</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 10066
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
ANNIE MARY KRONENBERG		10/31/71 1412 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION BALTIMORE, MD 21205		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		8. DATE OF BIRTH 01-13-93		9. AGE (In years last birthday) 78
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME CHARLES WIETSCHER		14. MOTHER'S MAIDEN NAME CATHERINE DIETZ		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-22-9010		17. INFORMANT Elizabeth K. Yowell 4225 Carwell Ave 21236
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Cardiomy. arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Acute M.I. DUE TO, OR AS A CONSEQUENCE OF: (C) ASCVD
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). pulmonary emboli				12 mins. 5 hrs
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from 10/19 1971 to 10/31 1971 that (1) (we) last saw the deceased alive on 10/31 1971 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Jerome E. Kurent				23B. DATE SIGNED 10/31/71
23C. PHYSICIAN'S NAME (Type) JEROME E. KURENT		23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 3, 71		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery
24D. LOCATION Baltimore Maryland		24E. STATE State		
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Dippel Brothers Inc 7110 Belair Rd.

2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. [REDACTED]
<div style="font-size: 1.5em; font-weight: bold;">W-362 71 10067</div> <div style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</div>				<div style="font-size: 1.5em; font-weight: bold;">71 10067</div> <div style="font-size: 1.2em; font-weight: bold;">1 53 PM</div>
1. NAME OF DECEASED (Type or Print) <i>ESAU Washington WATERS</i>		2. DATE AND HOUR OF DEATH <i>10-27-71 1 53 PM</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>+8 MGH (ER)</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BALTO</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>6103 Robin Hill Rd.</i>		
5. SEX <i>M</i>	6. RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-30-11</i>	9. AGE (In years last birthday) <i>60</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Consultant Teacher</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Health Dept.</i>		11. BIRTHPLACE (State or foreign country) <i>Ind</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Steven Waters</i>		
14. MOTHER'S MAIDEN NAME <i>Helen Coleman</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES 1944-1946</i>		
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Face sheet (ER)</i>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>10-27-71</i> 19 <i>135</i> to <i>10-27-71</i> 19 <i>153</i> that (I) (we) last saw the deceased alive on <i>never</i> 19 <i>153</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Manjwala</i>		23B. DATE SIGNED <i>10/27/71</i>		
23C. PHYSICIAN'S NAME (Type) <i>MANEJWALA</i>		23D. ADDRESS <i>MGH</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/30/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Wauke M.E.H.</i>
24D. LOCATION (City, town, or county) (State) <i>Cambridge Md</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 2 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Halley E. Ward Criswell M.D.</i>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-655 71 10068		BALTIMORE CITY HEALTH DEPARTMENT		71 10068	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Charles Foreman		10/29/71		1:45 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If Institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
45 The Good Samaritan Hospital		Md. Baltimore City			
5601 Loch Raven Blvd.		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Baltimore, Maryland 21212		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M	W			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Night Watchman		Noxell Corp.		09-07-88	
11. BIRTHPLACE (State or foreign country)		9. AGE (In years last birthday)		83	
England		United States			
12. CITIZEN OF WHAT COUNTRY?		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Charles Foreman		Claire Grubbs			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Unknown		215036364		Louise Foreman	
18. CAUSE OF DEATH		ADDRESS			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Same			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF			
ANTECEDENT CAUSES		ca of lung			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		5 months			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from October 8 1971 to October 29 1971 that (I) (we) lost saw the deceased alive on October 29 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
A. Ower M.D.				10-29-71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
A. ORE R.				Good Samaritan Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		11-1-71		Moreland Memorial Pk Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 2 1971		Robert E. Barber, M.D.		Frank A. Leitch 814 W 36th St	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10069	
<div style="display: flex; justify-content: space-between;"> 11-62071 10069 + </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MORSE, Theodore Maynard		October 29, 1971 4.55 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218			Maryland Carroll		
C. CITY OR TOWN			D. INSIDE CITY LIMITS?		
Westminster			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER					
49 Charles Street					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2-28-14	57	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Ret. Nurseman		Florist		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Oliver Morse			Hannah Powell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		1-24-44 to 4-10-46		Records VAH, 3900 Loch Raven Blvd., Balto., Md. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
2					Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from <u>October 16</u> 1971 to <u>October 29</u> 1971, that (we) last saw the deceased alive on <u>October 29</u> , 1971 and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
<i>Stephen Greenberg MD</i>					
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Stephen Greenberg			3900 Loch Raven Blvd., Balto., Md. 21218		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		11-2-71		GARDEN OF ETERNAL HOPE FINKSBURG MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 2 1971		Robert E. Talbot, M.D.		J. E. Zimkus, Jr., Westminster, MD	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY J. KESTER Koester		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> October 28, 1971		3. DATE PRONOUNCED DEAD Month Day Year Hour October 28, 1971 9:10 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 211 N. Linwood Avenue		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 601			
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 10-20-1885		10. AGE (In years last birthday) 86	E. STREET AND NUMBER 211 N. Linwood Avenue		
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF U.S.A.	13. FATHER'S NAME Vincent Pignataro		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Josephine Graziano	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 1918		17. SOCIAL SECURITY NO.		18. INFORMANT Adelaide Wedmore 232 N. Kenwood Ave.	
19. 124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type)		M.D. Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
				DATE SIGNED October 28, 1971	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-2-71	24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR B. Dabrowski 2818 E. Baltimore St.	

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UNITED STATES DEPARTMENT OF DEFENSE

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a standard memorandum format with multiple lines of text.]

PROCESSED

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

BALTIMORE CITY HEALTH DEPARTMENT				71 10071			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) John R. WEIPERT				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour October 27, 1971 M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1684 Dorley Avenue				3. DATE PRONOUNCED DEAD Month Day Year Hour October 27, 1971 8:15 P.M.			
6. SEX Male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH SEPT. 26-1915				10. AGE (In years last birthday) 56		11. BIRTHPLACE (State or foreign country) BALTO. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John WEIPERT		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER	
15. MOTHER'S MAIDEN NAME CECELIA PETRY				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO			
17. SOCIAL SECURITY NO. 212-09-3018				18. INFORMANT ADDRESS Philip VoELKER-2409 Louise Ave			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease				20. DATE OF OPERATION 2			
21. AUTOPSY? (Yes or No) Yes				22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
23. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
25. TIME OF INJURY (APPROX.)				26. HOW DID INJURY OCCUR?			
27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				28. DATE SIGNED October 28, 1971			
29. ACTUAL SIGNATURE Charles S. Springate M.D.				30. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
31. EXAMINER'S NAME (Type) Charles S. Springate, M.D.				32. DATE REC'D BY HEALTH DEPT. NOV 2 1971			
33. NAME OF REGISTRAR Robert E. Taylor, M.D.				34. FUNERAL DIRECTOR ADDRESS Krause Funeral Home-1216 S. Charles			
35. BURIAL CREMATION, REMOVAL (Specify) Burial				36. DATE 10/30/71			
37. NAME OF CEMETERY or CREMATORY Holy Redeemer				38. LOCATION (City, town, or county) (State) Baltimore, Md.			

ALCAID REX BOND

46 CENTS

YALIE / SPARTO

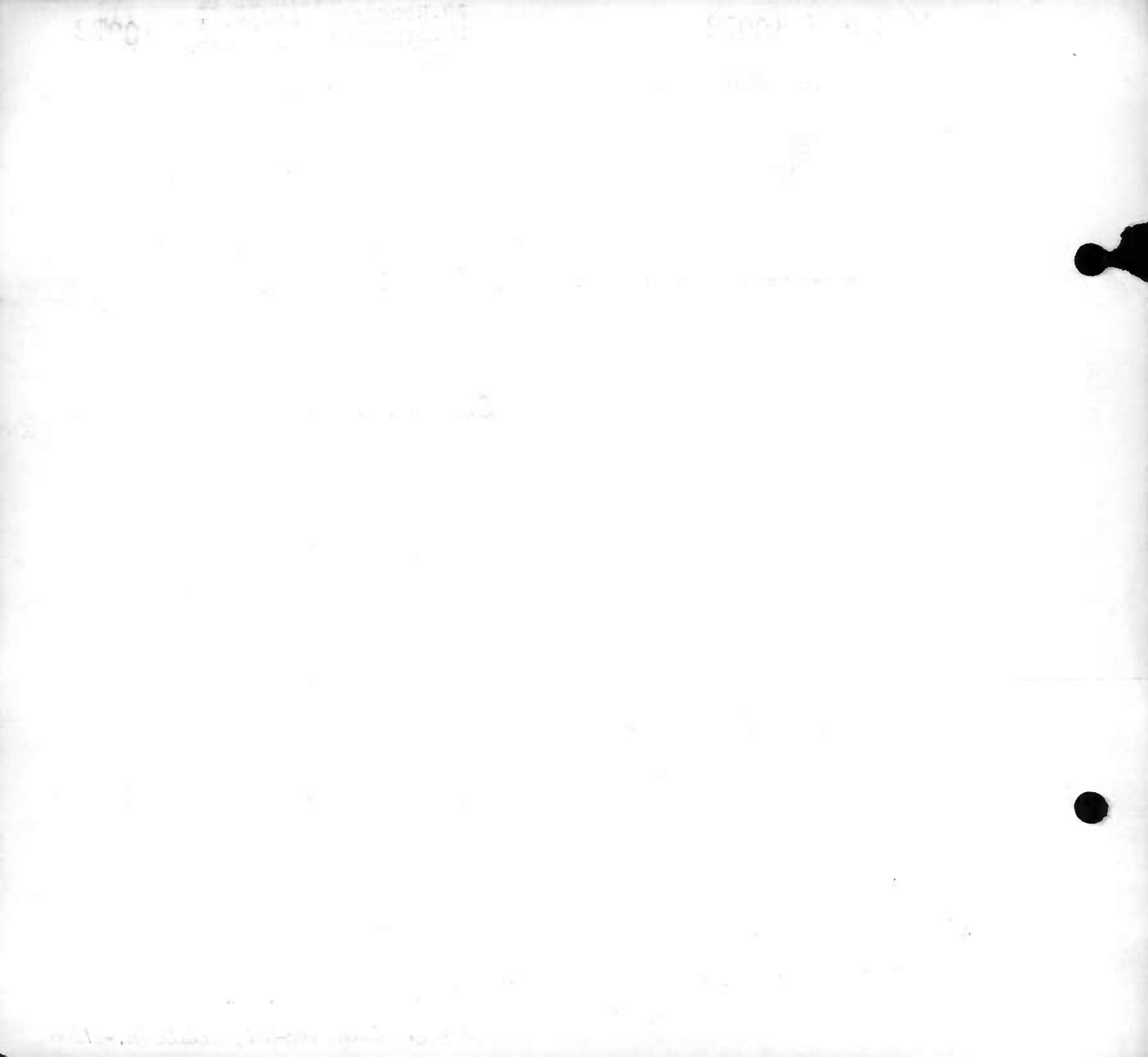
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10001

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT REG. NO. 42-19-0371 10072			
H-26071 10072 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) VIRGINIA A. HOSIER		2. DATE AND HOUR OF DEATH 10/26/71 530 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNIVERSITY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 2631	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		C. CITY OR TOWN BALTIMORE	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 4414 GLENARM AVE 21206	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		8. DATE OF BIRTH 7/21/54	9. AGE (In years last birthday) 17
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME CHARLES L. HOSIER		14. MOTHER'S MAIDEN NAME RUTH L. FORWARD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Charles L. Hosier-4414 Glenarm Ave		ADDRESS	
18. 734.1 CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. SYSTEMIC LUPUS ERYTHEMATOSUS			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/12 19 71 to 10/26 19 71 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Kenneth V. Eden MD		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) KENNETH V. EDEN M.D.		23D. ADDRESS UNIVERSITY HOSPITAL BALTO. MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 10-30-71	24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR John G. Miller Inc-6415 Belair Rd.-21206		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-430 71 10073		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 10073 REG. NO.
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ELLIOTT, Russell L. Sr.</u>		2. DATE AND HOUR OF DEATH <u>10-29-71</u> <u>345</u> P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1902</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hospital</u> <u>2025 W. Fayette Street</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Richard Roof. Co</u>		8. DATE OF BIRTH <u>08-10-10</u>
13. FATHER'S NAME <u>- Elliott</u>		14. MOTHER'S MAIDEN NAME <u>-</u>		9. AGE (in years last birthday) <u>61</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>22010-6392</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
17. INFORMANT <u>Chart</u>		ADDRESS		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
18. <u>712.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Pulmonary edema</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>about 12 hours.</u>
(B) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF:		(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>10/29</u> 19 <u>71</u> to <u>10/29</u> 19 <u>71</u> that (I) (<u>we</u>) last saw the deceased alive on <u>10/29</u> 19 <u>71</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.				
23A. SIGNATURE <u>Masa Hiro Sugawara M.D.</u>		23B. DATE SIGNED <u>10/29-71</u>		23C. PHYSICIAN'S NAME (Type) <u>MASAHIRO SUGAWARA M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>11/2/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Thomas J. Kennedy, Inc.</u>
24D. LOCATION (City, town, or county) (State)		24E. ADDRESS		
<u>Balto. Md 21223</u>		<u>1600 Hollins St.</u>		



FUNERAL DIRECTOR: IMPORTANT

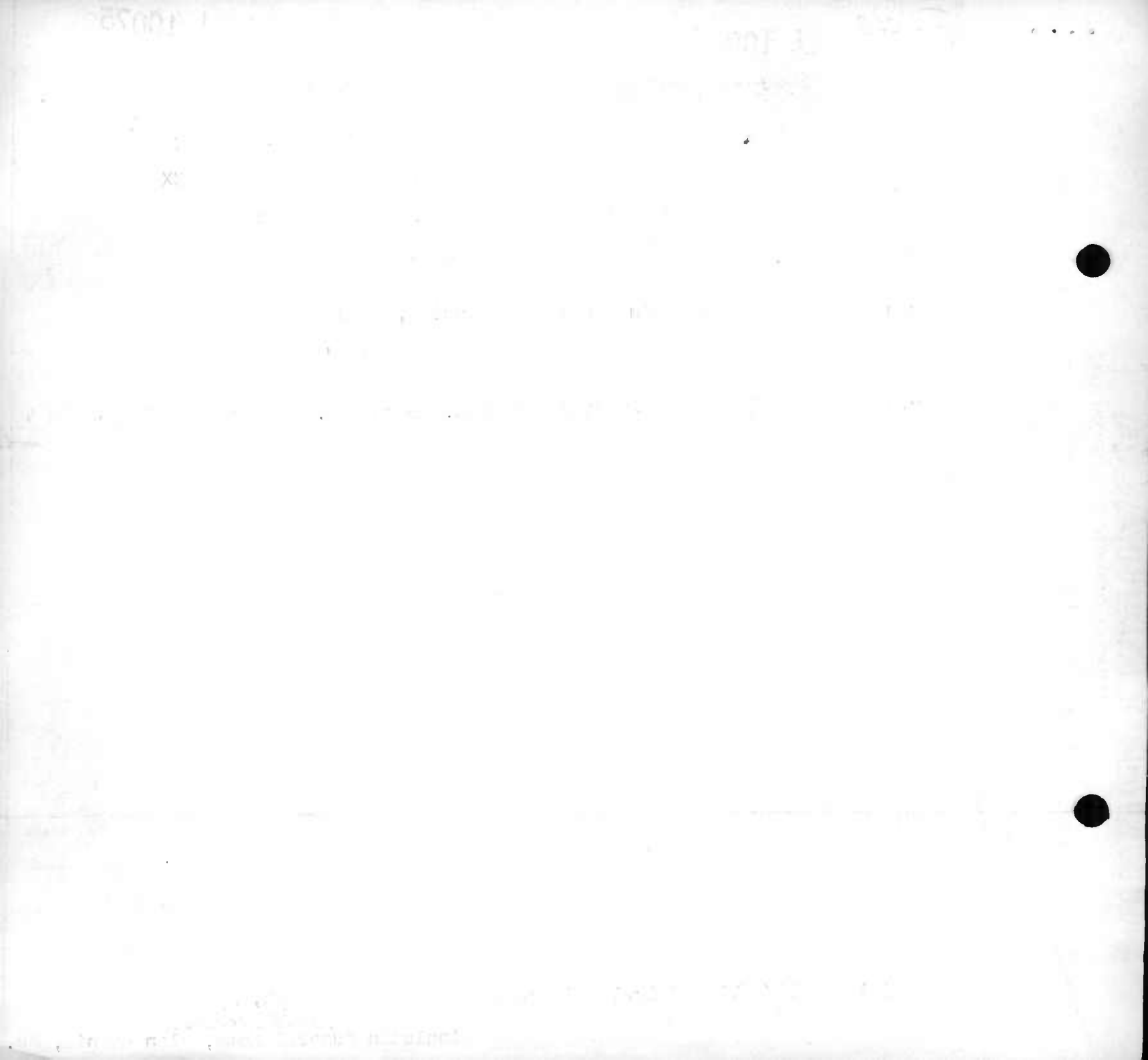
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-435 71 10074		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10074	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Blethen, Harry</u>		2. DATE AND HOUR OF DEATH <u>Oct 30, 1971 4:05 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>W. VIRGINIA</u> B. COUNTY <u>V45</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> <u>JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD. 21205</u>		C. CITY OR TOWN <u>HUNTINGTON</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1748 ELEVENTH AVE.</u>		5. SEX <u>MALE</u>		6. RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-17-01</u>		9. AGE (In years last birthday) <u>70</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRALER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>NATHAN W. BLETHEN</u>		14. MOTHER'S MAIDEN NAME <u>MARY ETTA PHIFER</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>234 07 3226</u>		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Perforation of Bowel</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Renal cell carcinoma with metastasis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>19 yrs.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Chu-shin chin MD.</u>		23B. DATE SIGNED <u>Oct 30, 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>CHU-SHIN CHIU MD.</u>	
23D. ADDRESS <u>Johns Hopkins Hospital, Balto. Md.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11-3-71</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Springhill Cemetery</u>		24D. LOCATION <u>Huntington W. VA.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>	
25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD.</u>		25C. FUNERAL DIRECTOR <u>Wm. Clark Brooks Towson, Inc.</u>		ADDRESS <u>Towson, Md.</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10075	
BIRTH NO. R-263 71 10075		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <div style="text-align: center; font-size: 1.2em;">RICHARD, Martin</div>			2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 10/29/71 12:30 a. m. </div>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="text-align: center; font-size: 1.2em;">The Johns Hopkins Hospital</div>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Massachusetts 8. COUNTY V 18 C. CITY OR TOWN Hyde Park D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 15 Mt. Pleasant Street		
5. SEX Male			6. RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator			10B. KIND OF BUSINESS OR INDUSTRY Westinghouse		9. AGE (In years last birthday) 49
11. BIRTHPLACE (State or foreign country) Dexter, Maine			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Maurice Richard			14. MOTHER'S MAIDEN NAME Dorothy O'Keefe		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II			16. SOCIAL SECURITY NO. 022/14/8669		17. INFORMANT Mrs. Frances R. Richard (wife) Same As 4
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <div style="text-align: center; font-size: 1.2em;">Aspiration</div> </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center; font-size: 1.2em;">Tracheo-Esophageal fistula</div> </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div>					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 9/5 19 71 to 10/29 19 71 that (we) last saw the deceased alive on 10/28 19 71 and that in (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <div style="text-align: center; font-size: 1.2em;">Robert Allan Rizza</div>				23B. DATE SIGNED 10/29/71	
23C. PHYSICIAN'S NAME (Type) <div style="text-align: center; font-size: 1.2em;">Robert Allan Rizza</div>				23D. ADDRESS <div style="text-align: center; font-size: 1.2em;">Johns Hopkins Hospital</div>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/2/71		24C. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	
24D. LOCATION (City, town, or county) (State) Hyde Park, Mass		25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971			
25B. NAME OF REGISTRAR Vander E. Vander A.D.		25C. FUNERAL DIRECTOR <div style="text-align: center; font-size: 1.2em;">Simoleton Funeral Home, Glen Burnie, Md.</div>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-240		71 10076		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10076	
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT			
1. NAME OF DECEASED (Type or Print) PASQUALE, ROBERT JOSEPH				2. DATE AND HOUR OF DEATH OCTOBER 29, 1971 7:45 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVE				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 1124 GLORIA AVE		21227	
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03 09 20	9. AGE (In years last birthday) 51	10. Under 1 Yr. Months: Days: Hours: Min.	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER WRITER			10B. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN PASQUALE				14. MOTHER'S MAIDEN NAME MARY VERANI PASQUALE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W W I I				16. SOCIAL SECURITY NO. 184 07 6390		17. INFORMANT BALTIMORE MD 21229 ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 200.1 I pulmonary edema hrs.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. hypoproteinememia days				(B) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). peritonitis, localized days				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION 2/8/13/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED biopsy		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from AUGUST 8 1971 to OCTOBER 29 1971 that (X) (we) last saw the deceased alive on OCTOBER 29 1971 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Charles R. Chaney				23B. DATE SIGNED 10/30/71		23C. PHYSICIAN'S NAME (Type) CHARLES R. CHANEY M.D. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 11-3-71		24C. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY	
24D. LOCATION YEADON, PA.				25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.				25C. FUNERAL DIRECTOR HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 10077	
CERTIFICATE OF DEATH				REG. NO. 71 10077	
BIRTH NO. B-520		71 10077			
1. NAME OF DECEASED (Type or Print) BAINES DELLA			2. DATE AND HOUR OF DEATH 10-31-71 10:35 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Arthurian Hospital of Maryland, 730, Ashburton Street, Baltimore MD-21216			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1607 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 11301 DUKELAND ST		
5. SEX Female	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-29-13	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Lamp Baines			14. MOTHER'S MAIDEN NAME Mollie Rick's		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-38-1315		17. INFORMANT ADDRESS Mrs Ardelia Langley 306 N. Fulton Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 707-01 9 Septicaemia Decubitus ulcers Malnutrition			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 2 months 6 months		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 10-21- 19 71 to 10-31- 19 71 that (I) (we) last saw the deceased alive on 10-31- 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Jason Samuel M.D.				23B. DATE SIGNED 10-31-71	
23C. PHYSICIAN'S NAME (Type) JASON SAMUEL M.D.		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov 4, 1971		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem Park	
24D. LOCATION (City, town, or county) Arbutus		24E. LOCATION (State) Md.			
25A. DATE RECEIVED BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Joseph L. Ray		25C. FUNERAL DIRECTOR ADDRESS 2732 W. North Ave	

2/5/002

7/29/66 - Adm.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10078	
71 10078				BIRTH NO.	
CERTIFICATE OF DEATH				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) RUTH SCOTT				10-31-71 8:11 A.M. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				A. STATE MARYLAND	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1807 N. BROADWAY	
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		8. DATE OF BIRTH 08-18-23	
				9. AGE (in years last birthday) 48	
13. FATHER'S NAME HARRY PURYEAR		14. MOTHER'S MAIDEN NAME EVA SCOTT		11. BIRTHPLACE (State or foreign country) Pa.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
17. INFORMANT William Scott		ADDRESS 1807 N. Broadway			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 430.01				CAUSE OF DEATH (A) IMMEDIATE CAUSE Ruptured berry aneurysm	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(B) DUE TO, OR AS A CONSEQUENCE OF: massive subarachnoid hemorrhage	
				(C) DUE TO, OR AS A CONSEQUENCE OF: Hypertension	
				UNKNOWN	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 10-31 19 71 to 10-31 19 71 that (we) last saw the deceased alive on 10-31 19 71 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) view the body after death.					
23A. SIGNATURE George Curlin M.D.				23B. DATE SIGNED 23rd Nov 71	
23C. PHYSICIAN'S NAME (Type) GEORGE CURLIN, M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-1-71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Westport, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.	
25C. FUNERAL DIRECTOR Clifford Funeral Home		25D. ADDRESS 1129 N. Calvert			

GEORGE CURLIN, M.D.

George Curlin M.D.

THE JOHNS HOPKINS HOSPITAL

237 W 31st St

10-31

10-31

21

10-31

21

YES

*Heard from
Marianne Suborodachewicz from page 3
3 in*

HARRY PURYEAR

FEMALE NEGRO

X

BALTIMORE, MD 21202
THE JOHNS HOPKINS HOSPITAL

EVA SCOTT

08-18-53 48

1807 N. BROADWAY
BALTIMORE

X

MARYLAND

10-31-51

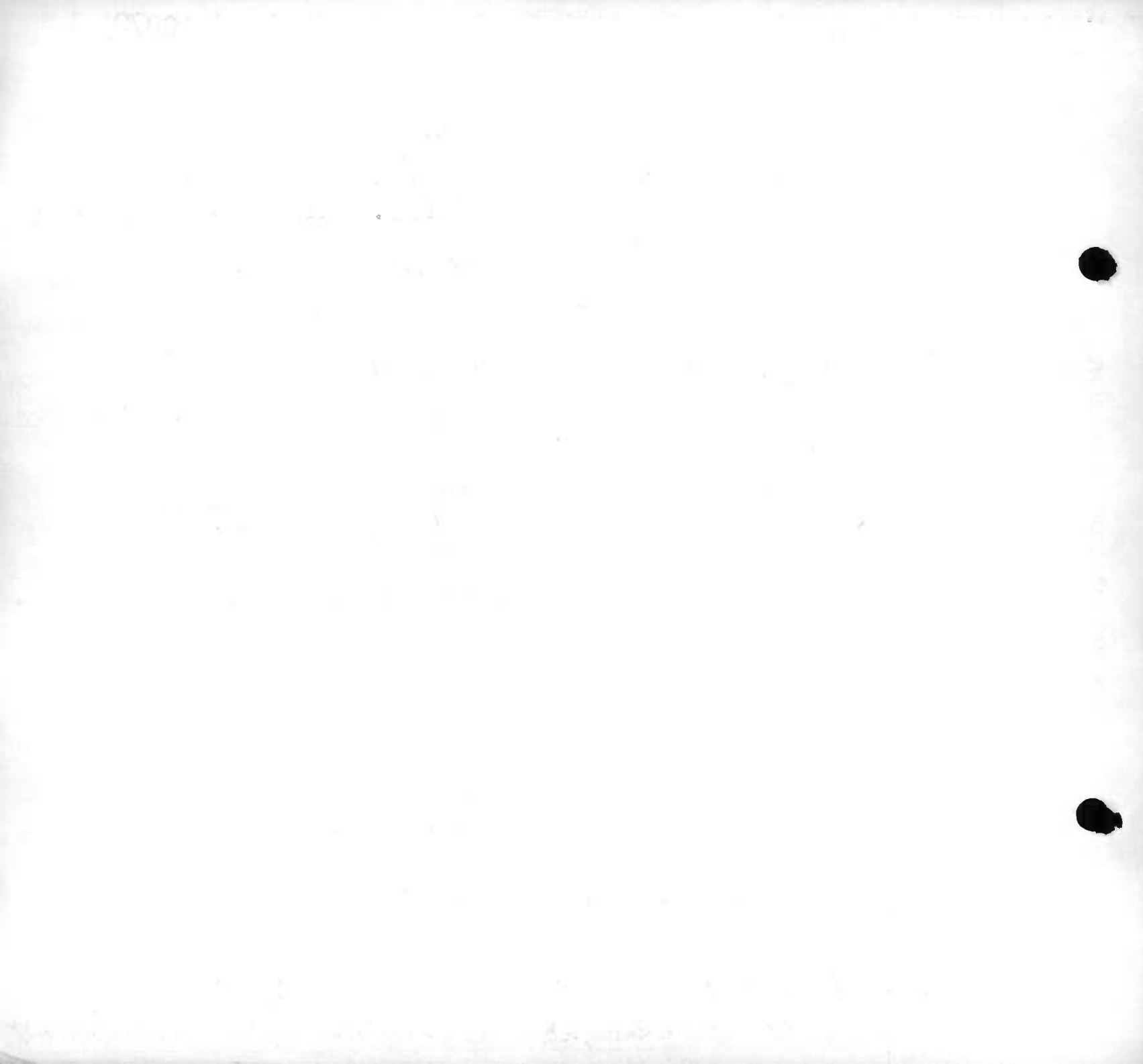
RUTH SCOTT

8:11 A.M.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

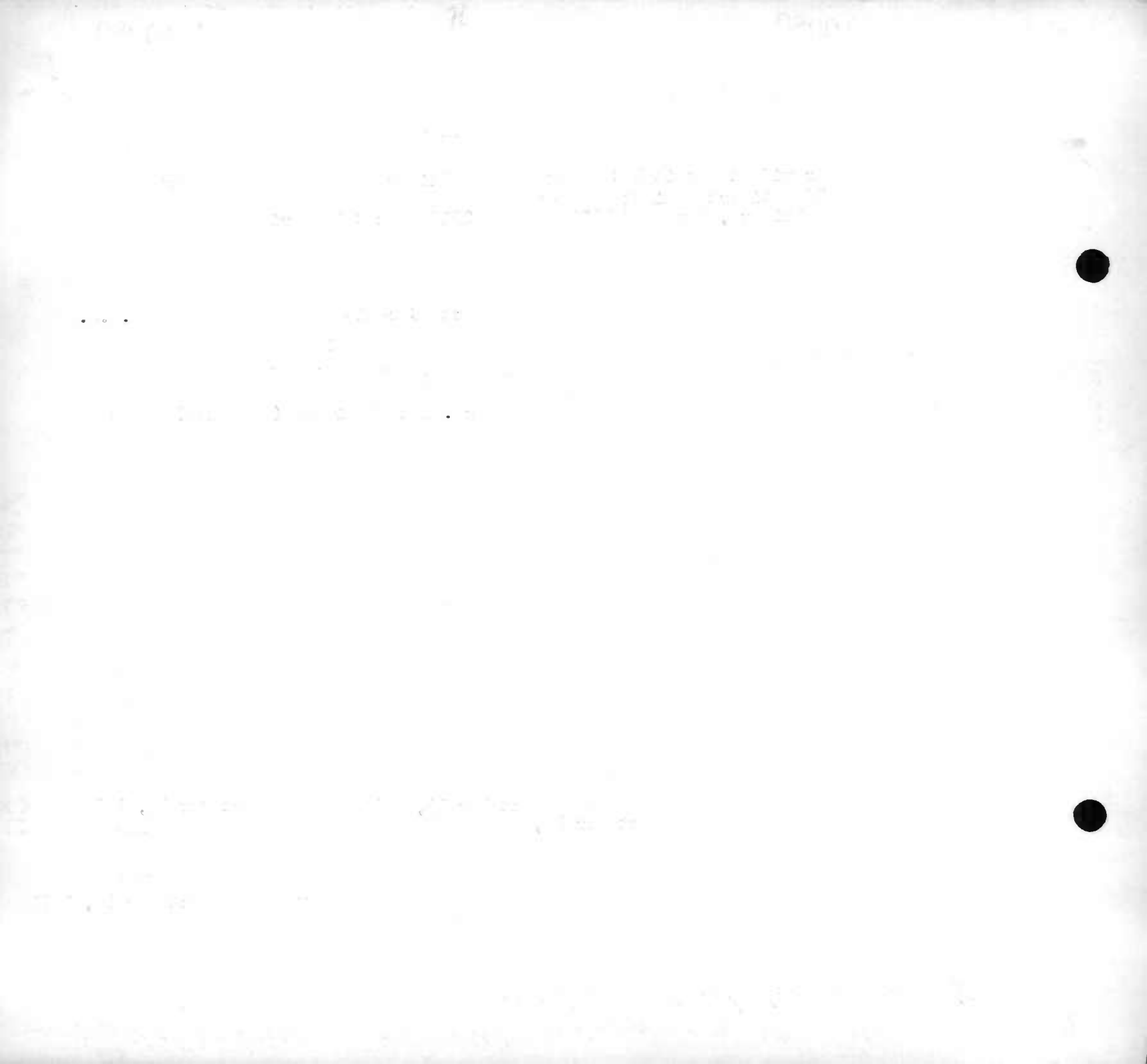
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 10079	
BIRTH NO. 71 10079		1. NAME OF DECEASED (Type or Print) Columbus Vaughn		2. DATE AND HOUR OF DEATH 1032 pm Oct 31 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 802		
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 1733 N. Patterson Park 21213		
5. SEX M	6. RACE N N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/02/02	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Lem Vaughn			14. MOTHER'S MAIDEN NAME Mahalia Smith		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT Maybell Vaughn-1733 Patterson Park		
18. 580 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardio pulmonary arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hemelia Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: Acute & Chronic Renal Failure (C) Several yrs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 7		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from October 29 19 71 to October 31 19 71 that (1) (we) lost saw the deceased alive on October 31 19 71 and that (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Alan Maurer MD				23B. DATE SIGNED 10-31-71	
23C. PHYSICIAN'S NAME (Type) R. ALAN MAURER				23D. ADDRESS 1620 McEldevy St. - Baltimore MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-4-71		24C. NAME OF CEMETERY OR CREMATORY MT. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Westport, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971			
25B. NAME OF REGISTRAR Robert E. Farber, MD.		25C. FUNERAL DIRECTOR Elliot Funeral Home-1129 N. Carroll St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M 610		71 10080		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10080	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>MURPHY, CALLIE</u>				2. DATE AND HOUR OF DEATH <u>10-30-71</u> <u>6-A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2716</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital Complex</u> <u>2600 Liberty Heights Avenue</u> <u>Baltimore, Maryland 21215</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female Negro</u>		6. RACE <u>Female Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-22-93</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <u>77</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Dallas Marshall</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie Simpson</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Ruth Robinson (Daughter)</u>	
18. <u>412.41</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>ASTEROSCLEROSIS CVD</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cachexia 20 to above</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>October 14, 1971</u> to <u>October 30, 1971</u> that (I) (we) last saw the deceased alive on <u>October 30, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Manuel G. Mercado</u>				23B. DATE SIGNED <u>October 30, 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>MANUEL G. MERCADO</u>	
23D. ADDRESS <u>PROVIDENT HOSP BALTO. MD. 21215</u>		23E. DEGREE <u>DEGREE</u>		23F. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23G. ATTENDING PHYS. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>10/30/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Family Plot</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD. 21215</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Thasman R. Hays</u>		25D. ADDRESS <u>635 N. Gibson</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. <u>71 10081</u>	
BIRTH NO. <u>71 10081</u>		1. NAME OF DECEASED (Type or Print) <u>Bell, Lillian Young</u>		2. DATE AND HOUR OF DEATH <u>10-31-71</u> <u>2:45</u> <u>PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2714</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Mt Sinai Nursing Home</u> <u>4615 Park Heights Ave</u>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-19-01</u>	
9. AGE (In years last birthday) <u>70</u>		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <u>Balto MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>For Domestic Purposes</u>				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Joseph Young</u>				14. MOTHER'S MAIDEN NAME <u>Martha Patterson</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-18-5355</u>		17. INFORMANT <u>Myrtle Young 815 N Carey St</u>		ADDRESS	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebrovascular Acc</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>HEVD</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/5/71</u> 19 <u>71</u> to <u>10/31/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/31</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Edward S. Kallins MD</u>				23B. DATE SIGNED <u>11/1/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>E.S. KALLINS MD</u>				23D. ADDRESS <u>6000 PARK HEIGHTS AV BALTIMORE MD 21215</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>11/1/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BALTD NATIONAL</u>		24D. LOCATION (City, town, or county) (State) <u>Balto MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Marshall D. Myers 635 N. Johnson St</u>		ADDRESS	



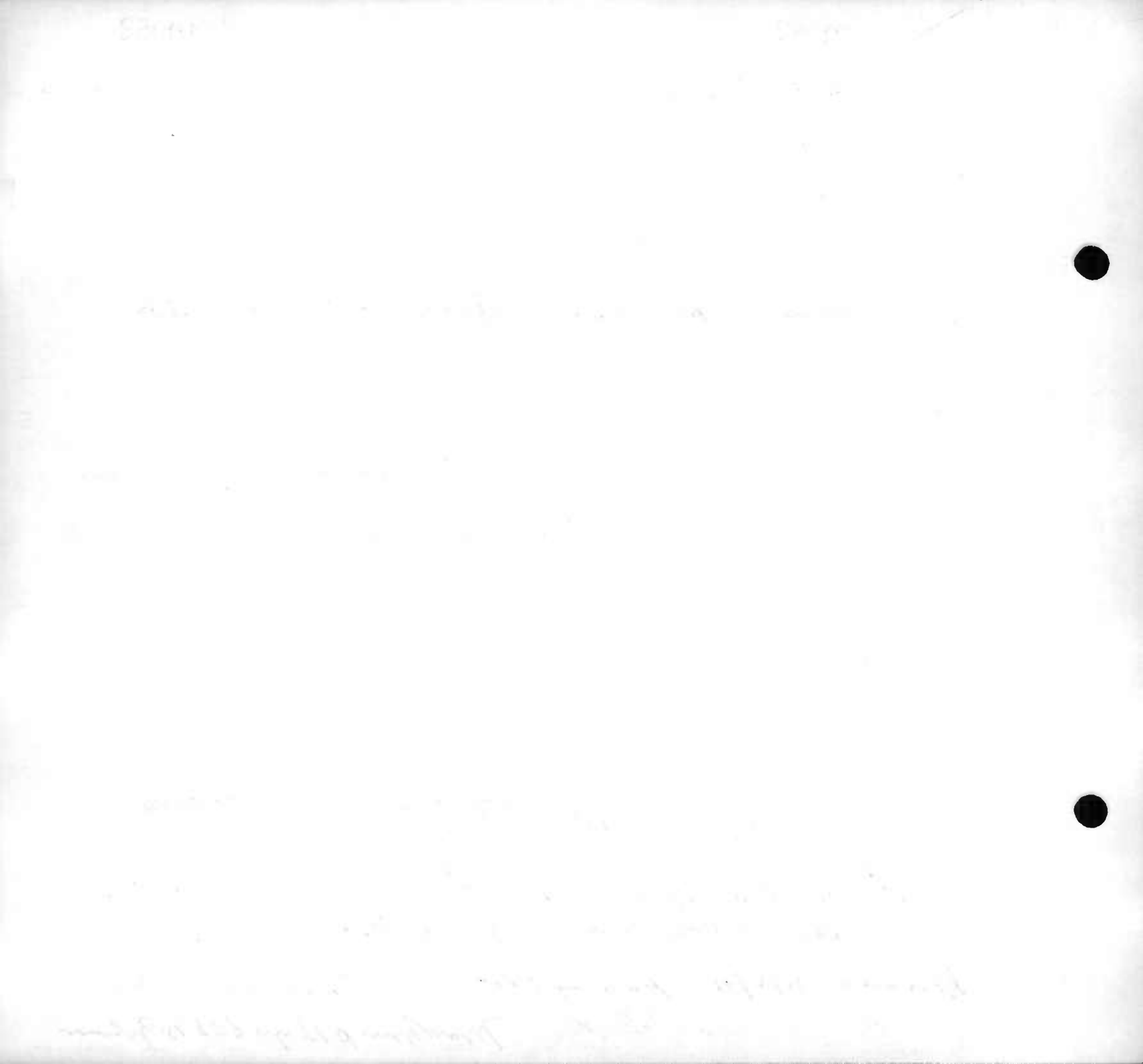
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 10082

BIRTH NO. <u>71 10082</u>		1. NAME OF DECEASED (Type or Print) <u>Mary Marsh</u>		2. DATE AND HOUR OF DEATH <u>Oct 29 1971 3 40 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Mt. Sinai Nursing Home</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Balto Md.</u> B. COUNTY <u>1506</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2924 Walbrook Ave</u>			
5. SEX <u>F.</u>	6. RACE <u>N.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-7-06</u>	9. AGE (in years last birthday) <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Centerville MD</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. David Marsh, Husband - Same</u>	
18. <u>437.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute Cerebro-Vascular</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cerebro Vascular Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>ac</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>10/24/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/24/71</u> 19__ to <u>10/29/71</u> 19__ that (I) (we) lost saw the deceased alive on <u>10/29</u> 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Edward S. Hallins MD</u>		23B. DATE SIGNED <u>11/1/71</u>		23C. PHYSICIAN'S NAME (Type) <u>EDWARD S. HALLINS MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/2/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Fairview Plot</u>	
24D. LOCATION (City, town, or county) (State) <u>Saxtons River</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>	
25C. FUNERAL DIRECTOR <u>John G. Brown</u>		25D. ADDRESS <u>6000 PARK HILLS AVE BALTIMORE MD 21215</u>		25E. ADDRESS <u>638 W. 9th St</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

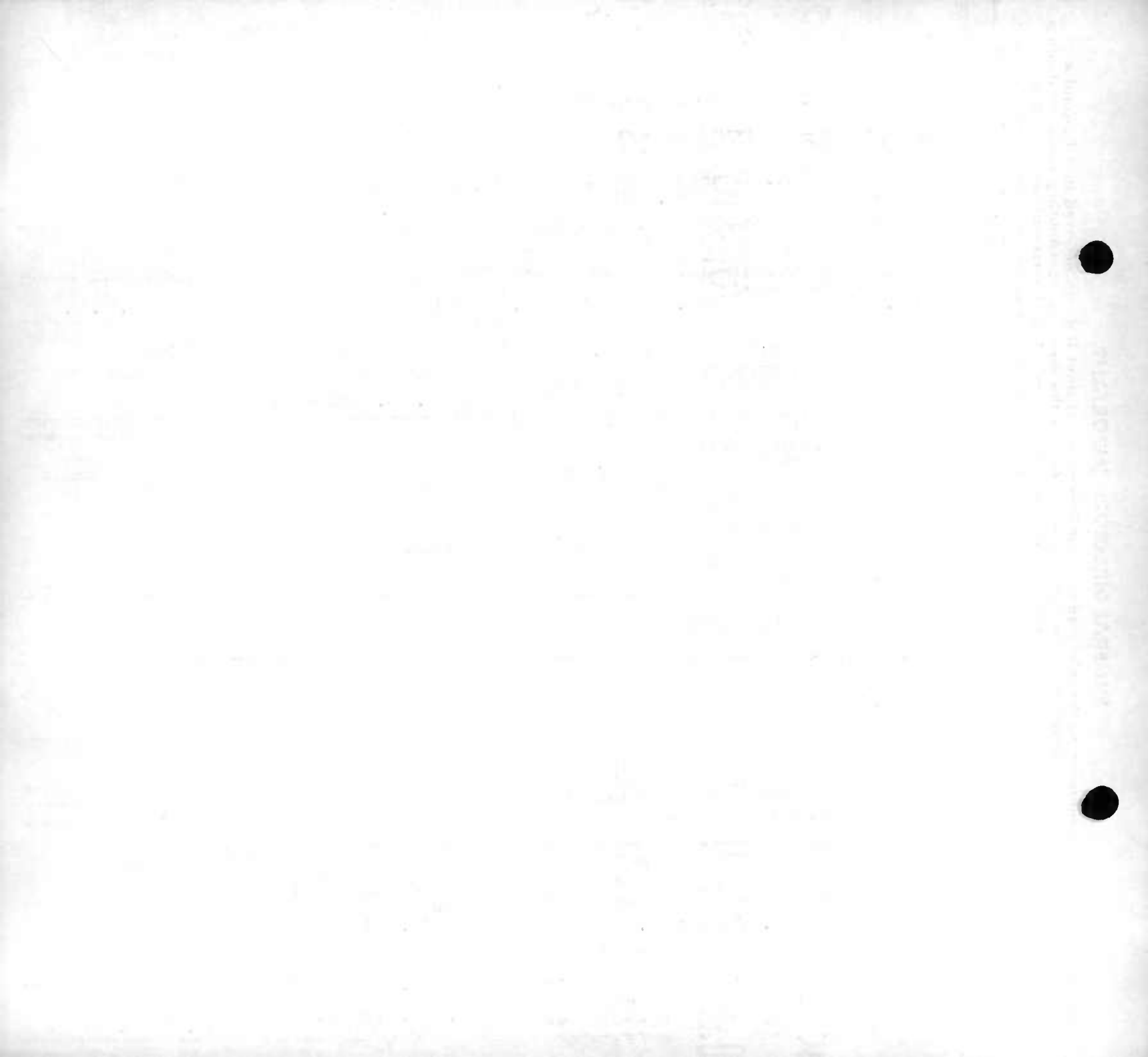
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10083</u>	
BIRTH NO. <u>71 10083</u>		1. NAME OF DECEASED (Type or Print) <u>Mr. Herrick F. Kidder</u>			
2. DATE AND HOUR OF DEATH <u>November 1, 1971</u> <u>10:34 a.m.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>91 Keswick (Home for Incurables)</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1307</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Wyman Park Apts.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/11/1888</u>	9. AGE (In years last birthday) <u>83</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Orange, New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>Gamillius George Kidder</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Farber</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-28-4476</u>		17. INFORMANT <u>Keswick Records</u> ADDRESS <u>700 W. 40th St.</u>	
18. <u>342X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Parkinsonism</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Arteriosclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 yrs</u> <u>7 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12 Nov 1965</u> to <u>1 Nov 1971</u> that (I) (we) last saw the deceased alive on <u>1 Nov 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Aubrey D. Richardson MD</u>		23B. DATE SIGNED <u>1 Nov 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>Aubrey D. Richardson MD</u>	
23D. ADDRESS <u>700 W. 40th Street #21211</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>			
24B. DATE <u>11-2-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Crematory</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, R.D.</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins, Sons Co.</u> ADDRESS <u>4905 York Rd. Baltimore, Maryland 21212</u>	

3925 Road Line

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
71-10084 CERTIFICATE OF DEATH					REG. NO. 71-10084					
BIRTH NO.					2. DATE AND HOUR OF DEATH					
1. NAME OF DECEASED (Type or Print) Mr. Clapham Murray, Jr.					0830, 1971 530 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					A. STATE & COUNTY					
00 3900 N. Charles Street Apt. 410					Maryland					
					C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
					E. STREET AND NUMBER					
					3900 N. Charles Street					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	10. UNDER 1 Yr. Months		11. UNDER 24 Hrs. Hours Min.		
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9-2-1884		87					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Ret'd. Lawyer			Md. Casualty Co.		Baltimore, Maryland			U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Clapham Murray, Sr.					Mary Grundy Gibson					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
No			212-10-3616		Mrs. C. Murray,			Same		
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					Probable Myocardial Infarction					
ANTECEDENT CAUSES					(B) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					Coronary Arteriosclerosis					
(C)										
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0						No				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (1) this hospital attended the deceased from 1955 to 1971 that (1) we last saw the deceased alive on Oct 29 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.										
23A. SIGNATURE					23B. DATE SIGNED					
Walter B. Buck M.D.					Nov 1, 71					
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS					
Dr. Walter B. Buck					15 E. Biddle Street					
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Burial			11-2-71		Christ Church Cemetery			West River, Md.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS	
NOV 2 1971			Robert E. Taylor, M.D.			H. W. Jenkins & Sons Co.			4905 York Road Balto., Md. 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 10085		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10085	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>WILLIAM KNIGHT</u>			
2. DATE AND HOUR OF DEATH <u>10-29-71</u> <u>11 AM</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>LUTHERAN Hospital of Md. Inc.</u>			
C. CITY OR TOWN. <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>901 EDMONDSON AVE.</u>		5. SEX <u>MALE</u> 6. RACE <u>NEGRO</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-10-97</u>		9. AGE (in years last birthday) <u>74</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Cora Godfrey</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Martha Knight 901 Edmondson Ave.</u>	
18. <u>162-1</u> I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PNEUMOTHORAX (LEFT)</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>(PROBABLY) CARCINOMA OF</u> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <u>THE LUNG.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>CACHEXIA, SENILITY.</u>			
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/27/1971</u> to <u>10/29/1971</u> that (I) (we) last saw the deceased alive on <u>10/29/1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Azad Cader</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>10/29/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>AZAD CADER</u>		23D. ADDRESS <u>LUTHERAN HOSP. BALTIMORE, MD 21216.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-3-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE</u>			

1875

1875

FUNERAL DIRECTOR: IMPORTANT

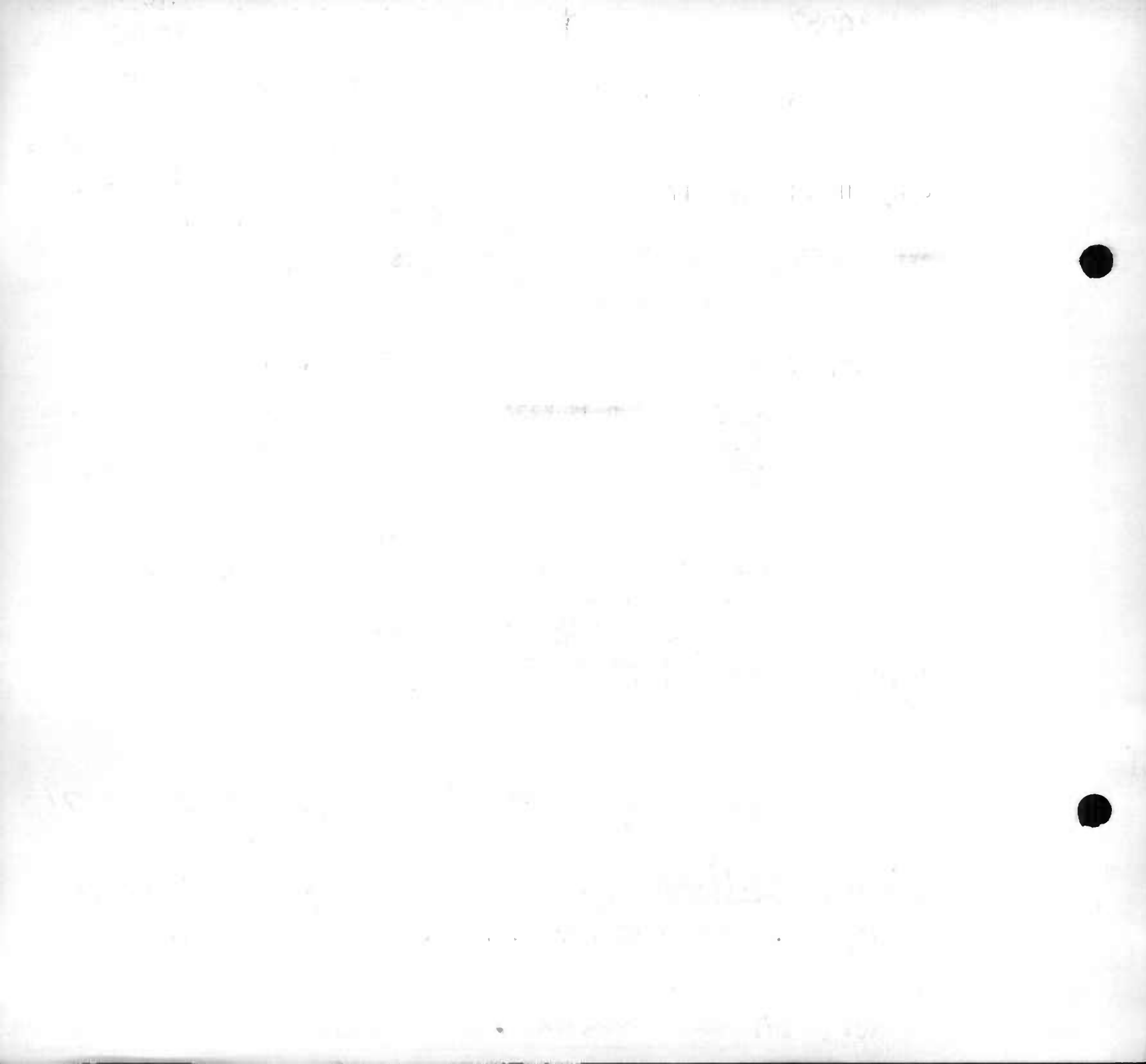
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10086</u>	
BIRTH NO. <u>71 10086</u>		2. DATE AND HOUR OF DEATH <u>10/28/71</u> <u>8:00</u> M.			
1. NAME OF DECEASED (Type or Print) <u>Charles Baskerville</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Lutheran Hospital</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>md.</u> B. COUNTY <u>2831</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>2/2/03</u>		9. AGE (in years, lost birthday) <u>68</u>		10. IF Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Governor Club</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Baskerville</u>		14. MOTHER'S MAIDEN NAME <u>Sarah ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-18-0656</u>		17. INFORMANT <u>Mrs. Lena Baskerville 3703 Parkview Ave</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>157.9 I</u> <u>metastatic Abdominal Ca</u> <u>primary site unknown</u> <u>poss. Pancreatic Ca.</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Since adm.</u> <u>19 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes) or No <input checked="" type="checkbox"/> No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/9</u> 19 <u>71</u> to <u>10/28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> M.D.		23B. DATE SIGNED <u>10/28/71</u>		23C. PHYSICIAN'S NAME (Type) <u>YOUNG Sook Kim, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-2-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley, R.D.</u>		25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10087	
71 10087		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) COLES, LEROY ANTHONY SR.		10/31/71 3PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY	
		1307	
		C. CITY OR TOWN BALTIMORE	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1008 W 43RD STREET	
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/30/02
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARRIER		10B. KIND OF BUSINESS OR INDUSTRY POST OFFICE	9. AGE (In years last birthday) 69
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME COLES, STEPHEN		14. MOTHER'S MAIDEN NAME CEASERS, IDA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WORLD WAR II		16. SOCIAL SECURITY NO. 220-38-7734	
		17. INFORMANT Stella M. Coles	
		ADDRESS 1008 W. 43rd. Street	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ARRYTHMIA CARDIAC ARREST SECONDARY TO MYOCARDIAL ISCHEMIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II SBE, MI, CHF		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SCCONDARY TO MYOCARDIAL ISCHEMIA (B) DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 10/29/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED MI	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from OCT 25 19 71 to OCT 31 19 71 and that (I) (we) last saw the deceased alive on OCT 31 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Wayne Leadbetter		23B. DATE SIGNED 10/31/71	
23C. PHYSICIAN'S NAME (Type) DR. WAYNE LEADBETTER M.D.		23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-4-71	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AVE.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10088

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

SADIE WARD

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3. DATE

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

5-12-1898

10. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1628 Druid Hill Avenue

11. BIRTHPLACE (State or foreign country)

Greenwood, Delaware

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

217-16-3478

18. INFORMANT

ADDRESS

Mr. John N. Ward-1628 Druid Hill Ave.

19. 410.94-250.9
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHII
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

Diabetes Mellitus

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING
CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/27/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-01-71

24C. NAME of CEMETERY or CREMATORY

Baltimore National

24D. LOCATION

(City, town, or county)

(State)

Baltimore,

Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 2 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Mary-Elizabeth Law 802 Madison Avenue

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. **71 10089**

BIRTH NO. **71 10089**

1. NAME OF DECEASED
(Type or Print)

BEATRICE T BROWN

2. DATE AND HOUR OF DEATH

10/30/71 8:35 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

2904 WINDSOR AVE.

5. SEX

F

6. RACE

N

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9/4/03

9. AGE (In years last birthday)

68

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

SOUTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

SAMUEL PARKER

14. MOTHER'S MAIDEN NAME

MATILDA CALHOUN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

216-18-7001

17. INFORMANT

ADDRESS

Mrs. Othella Dixon-4730 Wakefield Rd. Apt. 301

18.

487.01

CAUSE OF DEATH

FAILURE

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: **Acute Chronic Heart**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2 NONE

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from **10/27/71** 19 to **10/30/71** 19 that (we) last saw the deceased alive on **10/30** 19 **71** and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.

23A. SIGNATURE

L.B. Barnett, MD

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

10/30/71

23C. PHYSICIAN'S NAME (Type)

L.B. BARNETT, MD

DEGREE

23D. ADDRESS

UNIVERSITY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11-4-71

24C. NAME of CEMETERY or CREMATORY

Baltimore National

24D. LOCATION

(City, town, or county)

Baltimore,

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 2 1971

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Mary-Elizabeth Law 802 Madison Avenue

Department of Health

82

83

2

20-18-1001

112

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10090	
CERTIFICATE OF DEATH					
BIRTH NO. 71 10090		1. NAME OF DECEASED (Type or Print) Juanita Judge			
2. DATE AND HOUR OF DEATH 10/29/71 5:30 AM		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY WEST MARYLAND		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hosp 839 Linden Ave, Balt Md			
5. SEX F		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11/6/21		9. AGE (in years last birthday) 49		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Willie Judge		14. MOTHER'S MAIDEN NAME MARY EVERETT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 239-24-7443		17. INFORMANT CHART	
18. 303.21		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hepato-renal failure - 3 wks			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Chronic Alc. DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) ?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/15 19 71 to 10/29 19 71 that (I) (we) last saw the deceased alive on 10/29 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard H. Baffert MD				23B. DATE SIGNED 10/28/71	
23C. PHYSICIAN'S NAME (Type) John M O'Day		23D. ADDRESS 12 Woodland Ct, Laurel, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-3-71		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	
24D. LOCATION Arbutus, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971			
25B. NAME OF REGISTRAR James C. Barber MD		25C. FUNERAL DIRECTOR Mary-Elizabeth Law			
25D. ADDRESS 802 Madison Avenue					

PM 1-18/11 *

12/12

12/12/11

12/12/11

12/12/11

12/12/11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10091</u>	
BIRTH NO. <u>P-412</u>		71 <u>10091</u>			
1. NAME OF DECEASED (Type or Print) <u>CLIFFORD PHELPS</u>			2. DATE AND HOUR OF DEATH <u>10/30/71</u> <u>400 A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>ANNE ARUNDEL</u> <u>5200</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 UNIVERSITY OF MD HOSPITAL</u>			C. CITY OR TOWN <u>Prosser Md.</u> D. INSIDE CITY LIMITS? <u>XXXXX</u> NO <input checked="" type="checkbox"/>		
			E. STREET AND NUMBER <u>Mountain Rd.</u> RT. 13, BOX 417		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/4/67</u>	9. AGE (In years last birthday) <u>64</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAR OWNER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>WALTER PHELPS</u>			14. MOTHER'S MAIDEN NAME <u>MARY JOYCE</u>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218 18 1910</u>		17. INFORMANT <u>Mrs. Irene S. Phelps (wife)</u> ADDRESS <u>CHART</u> SAME AS #13	
18. <u>231.31</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>HEMIPYRYSIS WITH</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ASPIRATION</u> (B) <u>TUMOR OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>BRONCHOSCOPY</u> <u>10/29</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES THORAX</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>OCT 29</u> 19 <u>71</u> to <u>OCT 30</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>OCT 30</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lawrence A. Fleming MD</u> DEGREE				23B. DATE SIGNED <u>10/30/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>LAWRENCE A. FLEMING MD</u> DEGREE				23D. ADDRESS <u>UNIVERSITY OF MD. HOSP</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>NOV. 2/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>CEDAR HILL CEMETERY</u>	
		24D. LOCATION (City, town, or county) (State) <u>BROOKLYN, RFD, MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Feltz, MD</u>		25C. FUNERAL DIRECTOR <u>Singleton</u> ADDRESS <u>SINGLETON FUNERAL HOME GLEN BURNIE, MD.</u>	

1000

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X 1000

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1000

1000

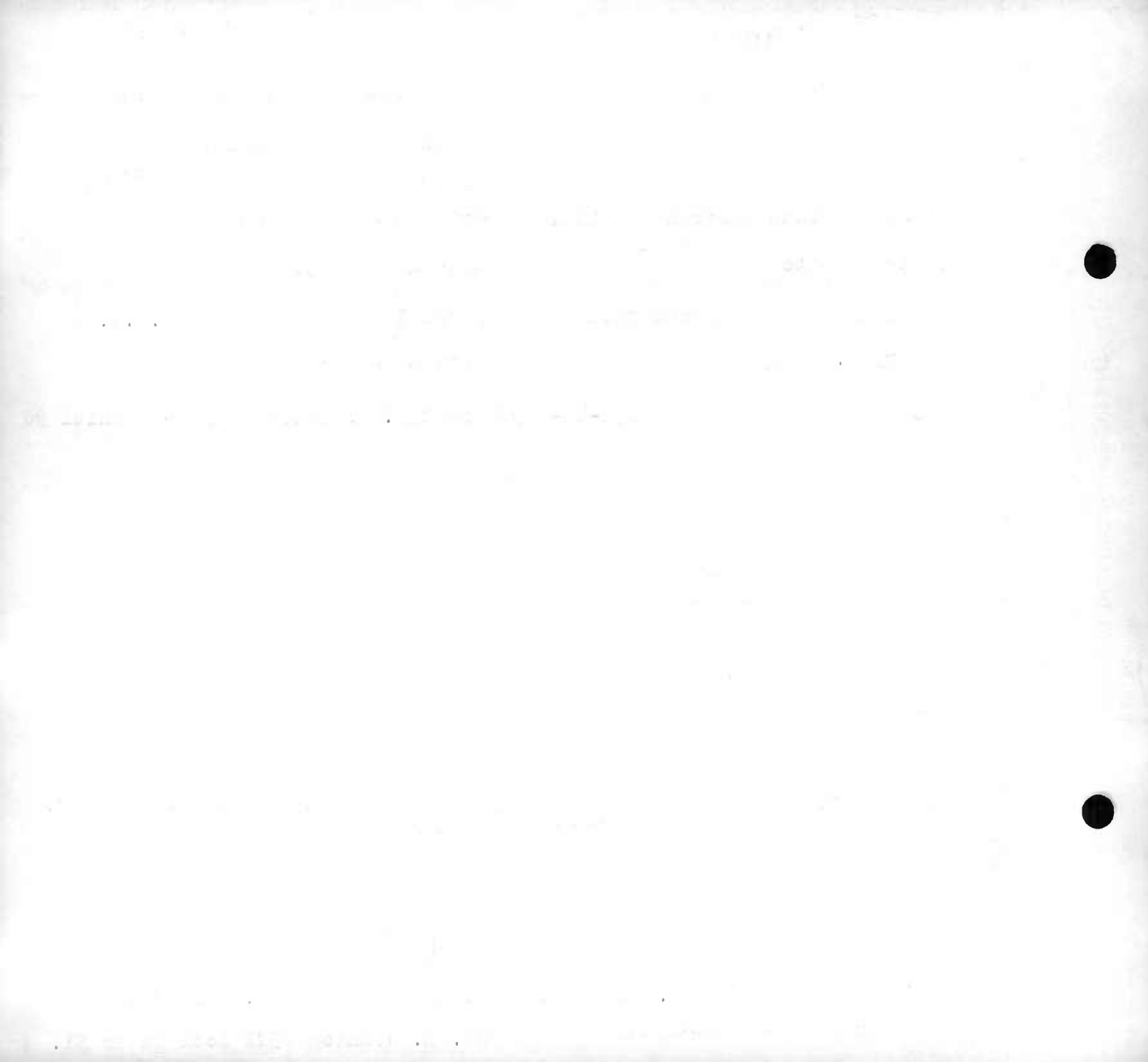
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-252 71 10092				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		71 10092	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
		BICKING; IRIS M				OCTOBER 29, 1971		3:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL					A. STATE MARYLAND				
					B. COUNTY ANNE ARUNDEL 5200				
					C. CITY OR TOWN GLEN BURNIE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 1531 TIEMEN DR 21061									
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/01/95	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER (retired)			10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE GROFF					14. MOTHER'S MAIDEN NAME ANNA SMITH XXXXXXXX				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 212 01 6116		17. INFORMANT Mr. Howard R. Bicking (son)			ADDRESS Same As #4	
					ST. AGNES HOSPITAL RECORDS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE Septicemia DUE TO, OR AS A CONSEQUENCE OF: (B) Caton-vesicofistulae DUE TO, OR AS A CONSEQUENCE OF: (C) Carcinoma of colon			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs. 4 weeks ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					ASCVD			4 yrs.	
19A. DATE OF OPERATION 10/20/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED intestinal obstruction			20A. AUTOPSY (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 27 19 71 to OCTOBER 29 19 71 that (I) (we) last saw the deceased alive on OCTOBER 29 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Charles R. Chaney M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 10/29/71	
23C. PHYSICIAN'S NAME (Type) CHARLES CHANEY, M.D.					23D. ADDRESS BALTIMORE, MARYLAND 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVE				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE NOV. 2 1971		24C. NAME OF CEMETERY OR CREMATORY LODGE PARK CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Singleton		ADDRESS Singleton Home			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 10093</p>	
<p>T-653 71 10093</p>			
<p>BIRTH NO. 1. NAME OF DECEASED (Type or Print) MARION FRANCES THORNTON</p>		<p>2. DATE AND HOUR OF DEATH October 29, 1971 12:05 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION 49 North Charles General Hospital</p>		<p>C. CITY OR TOWN 21234 D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
		<p>E. STREET AND NUMBER 1829 Loch Shiel Road</p>	
<p>5. SEX Female</p>	<p>6. RACE White</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 2/24/15</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Education</p>	
<p>11. BIRTHPLACE (State or foreign country) Pennsylvania</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME Harry S. Kelly</p>		<p>14. MOTHER'S MAIDEN NAME Martha Hanley</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. 172-12-9650</p>	
		<p>17. INFORMANT Frank R. Thornton 1829 Loch Shiel Rd</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CEREBRO-VASCULAR ACCIDENT</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT</p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION 0</p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No)</p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (this hospital) attended the deceased from 10/22 to 10/29 1971 that (I) (we) last saw the deceased alive on 10/29 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Rufino G. Montenegro</p>			<p>23B. DATE SIGNED</p>
<p>23C. PHYSICIAN'S NAME (Type) RUFINO G. MONTENEGRO</p>			<p>23D. ADDRESS 28 ave Charles Street Balto. Md.</p>
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>	<p>24B. DATE 11/2/71</p>	<p>24C. NAME of CEMETERY or CREMATORY St. Alphonse Cemetery</p>	<p>24D. LOCATION (City, town, or county) (State) Woodstock, Maryland</p>
<p>25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971</p>	<p>25B. NAME OF REGISTRAR Robert E. Taylor</p>	<p>25C. FUNERAL DIRECTOR Wm. E. Johnson 8521 Loch Raven Bl.</p>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CARRIE NICOLL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1500 E. Lanvale St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 31 1971 5:15 p M.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Dec. 23, 1881		10. AGE (In years lost birthday) 89	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Mary Rever	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 213 01 2054	
18. INFORMANT Mrs Margaret Lang		ADDRESS 5936 Glenkirk Road	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) no	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>R S Fisher</i> M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11-1-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/3/71	
24C. NAME OF CEMETERY or CREMATORY Jerusalem Church		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Henry Sander & Sons Inc.		ADDRESS Baltimore, Maryland 21213	

Memorandum

10001 13

10001 13

TO : Mr. Tolson

FROM : Mr. Clegg

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR THE RECORD

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620 71 10095		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 10095	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Edward Parks</u>		2. DATE AND HOUR OF DEATH <u>10/30/71 5:30 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD Maryland</u> B. COUNTY <u>1703</u>		5. CITY OR TOWN <u>Balt. 21201</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hosp.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <u>M</u>		7. RACE <u>N</u>		8. DATE OF BIRTH <u>8/23/22</u>	
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		10. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) <u>49</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Winston-Salem NC</u>	
13. FATHER'S NAME <u>Edward Parks</u>		14. MOTHER'S MAIDEN NAME <u>Susie Parks</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>090-18-6393</u>		17. INFORMANT <u>Susie Parks - 60 W. Park Rd. White Plains, NY</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Esophageal Varices</u>			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Portal hypertension</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>Cirrhosis</u>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>10/27/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/27/71</u> 19 to <u>10/30/71</u> 19 that (I) (we) last saw the deceased alive on <u>10/30/71</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Donald Hiscop, MD</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>10/30/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>DONALD HISCOP MD</u>		23D. ADDRESS <u>Maryland Gen. Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-4-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Rural Cemetery</u>	
24D. LOCATION <u>White Plains, N.Y.</u>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Mortimer & Dyett F.H. 1201-1205</u>	

41

Alfreda's letter

to her mother

at the 1st of May

1841

Alfreda's letter to her mother at the 1st of May 1841

FUNERAL DIRECTOR: IMPORTANT

This certificate must be completed by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		71 10096	
H-455 71 10096		71 10096	
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>James S. Holman</u>		2. DATE AND HOUR OF DEATH <u>10/30/71</u> <u>6:15</u> <u>A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>2001</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital of Md.</u>		C. CITY OR TOWN <u>Baltimore</u>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<h2 style="margin: 0;">CERTIFICATE AMENDED</h2> <p style="margin: 0;"><u>1-28-72</u></p>		E. STREET AND NUMBER <u>2006 W. Lexington St.</u>	
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-09</u>
9. AGE (in years last birthday) <u>62</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <u>Phila. Pa.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Miles Holman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Brickford</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-10-7679</u>	17. INFORMANT <u>Sarah Holman</u>
18. <u>16211</u> I		ADDRESS <u>2006 W. Lexington St.</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Respiratory distress</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Terminal Lung Ca</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Terminal Lung Ca</u>	
		(B) <u>multiple metastases</u> DUE TO, OR AS A CONSEQUENCE OF:	
		(C) _____	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>10/29/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Yes.</u>	
20A. AUTOPSY? (Yes or No) <u>Yes.</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/29/71</u> to <u>10/30/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/30/71</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>10/30/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>YOUNG SOOK KIM, M.D.</u>		23D. ADDRESS <u>Lutheran Hosp. of Maryland</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>11-3-71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Abertus Mem Pk</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>	
25C. FUNERAL DIRECTOR <u>Morton D. F. H.</u>		ADDRESS <u>1701 - Laurens St.</u>	

1-28-1972 - Correction form from Funeral Director HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 10097	
BIRTH NO. J-520 71 10097					
1. NAME OF DECEASED (Type or Print) Jones, Juanita T.		2. DATE AND HOUR OF DEATH 10-28-71 5:30 PM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 1604			
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran, Hosp.		C. CITY OR TOWN Baltimore, Md		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 2013-Rayner Ave			
5. SEX F	6. RACE N N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-29-14	9. AGE (In years last birthday) 55	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Helene Smith			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-24-7784		17. INFORMANT Julia Griffin	
		ADDRESS 4850-Clifton Ave.			
18. 736.01		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C V A		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hypertension DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 10/28		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/28 19 71 to 10/28 19 71 that (I) (we) last saw the deceased alive on 10/28 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 10/28/71			
23C. PHYSICIAN'S NAME (Type) YOUNG Sook Kim, M.D.		23D. ADDRESS Lutheran Hosp. 2 Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-1-71		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memory Park	
24D. LOCATION Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Robert E. Taylor, M.D.	
		ADDRESS 1701-Lawrence St.			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10098

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLEARENCE FEATHERSTONE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 31 1971 1:06p M.	
6. SEX male		7. RACE negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1607	
9. DATE OF BIRTH July 12, 1913		10. AGE (in years lost birthday) 58 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Clarkton, North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		13. FATHER'S NAME Unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No No		15. MOTHER'S MAIDEN NAME Unknown	
17. SOCIAL SECURITY NO. 269-094845		18. INFORMANT ADDRESS Cornelia Featherstone 1509 Hilton Street	
19. 412.21 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive & arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11-1-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-4-71	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		ADDRESS 1701 Laurens St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-263		71 10099		BALTIMORE CITY HEALTH DEPARTMENT		71 10099	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Thomas Richardson</u>				2. DATE AND HOUR OF DEATH <u>30 Oct 71</u> <u>17:30</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Key Circle Hospice</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>605</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>214 Bethel Court #21231</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-14-1880</u>	9. AGE (in years last birthday) <u>91</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>City Employee</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. City Housing</u>		11. BIRTHPLACE (State or foreign country) <u>Balti. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-03-8445</u>		17. INFORMANT <u>Thelma Hall - 210 - Bethel Ct.</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>491X I</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Arteriosclerotic Heart Disease</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs</u> <u>years</u> <u>ys</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1 Oct 71</u> 19 <u>71</u> to <u>30 Oct</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>25 Oct</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE <u>James H. Hall, M.D.</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>30 Oct 71</u>	
23C. PHYSICIAN'S NAME (Type) <u>James H. Hall, M.D.</u>				23D. ADDRESS <u>2430 Chetwood Circle Timonium, Md. 21093</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>11-4-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Not. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Michael J. Taylor</u>		ADDRESS <u>1201 E. Waverly St</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. 71 10100	
BIRTH NO. 71 10100		1. NAME OF DECEASED (Type or Print) ROBERTA L. BAWEY		2. DATE AND HOUR OF DEATH Oct. 30, 1971 3:00 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland & COUNTY BALTO 5300			
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
South Baltimore General Hosp		3001 S. Harman, Balto, Md. 21230		E. STREET AND NUMBER 601 S. Avondale Rd.			
5. SEX F	6. RACE B	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-10-28	9. AGE (In years last birthday) 43	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUREAU of REC			11. BIRTHPLACE (State or foreign country) Virginia Roanoke		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Roberto Chapman			14. MOTHER'S MAIDEN NAME Eva Dean				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 219-22-8549		17. INFORMANT EVAN D Bawe y-601-S. Avondale Rd.		
18. 5-24-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute hemorrhagic pancreatitis				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: Ischemic Intestine				
			(C) Chronic cholecystitis & cholelithiasis				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Hypertension				
19A. DATE OF OPERATION 10-30-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute abdomen		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx) 1 Month 1 Day (Year) 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10-28-71 19 71 to 10-30-19 71 that (I) (we) lost saw the deceased alive on 10-30 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature] M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10-30-71	
23C. PHYSICIAN'S NAME (Type) R. CANTERANOS DEGREE				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11-2-71		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park Baltimore, Md		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR [Signature]		ADDRESS 1901 - [Signature]	

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 10012 Hanner, Potts, May 21, 1930
 2-10-38
 43

Virginia
 Gus Dean

Robert Chapman

Great Smith's Mountain
 Jackson, N. C.
 Chas. Chiswick & Co.
 1930

10-30
 Great Smith's Mountain

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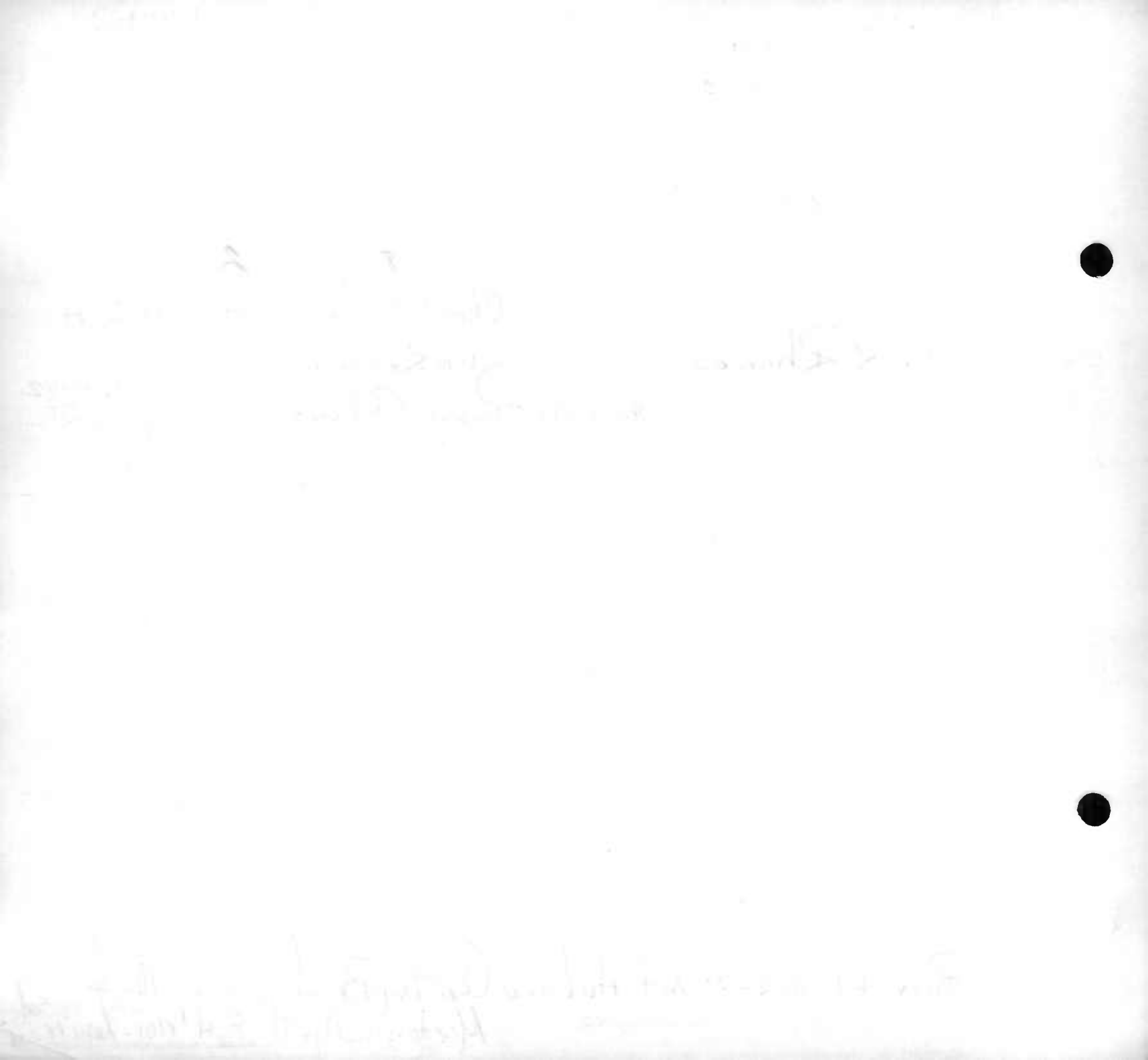
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10101</u>	
D-151 71 10101		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>DAVENPORT THURMAN</u>			2. DATE AND HOUR OF DEATH <u>10-29-71</u> <u>9:25 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>ST.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>North Charles General</u>			C. CITY OR TOWN <u>BALTO. MD. 21218</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-6-12</u>	9. AGE (in years last birthday) <u>58</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED FROM BETH STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia, Keyesville</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			13. FATHER'S NAME <u>DAVENPORT, ANDERSON</u>		
14. MOTHER'S MAIDEN NAME <u>CARTER</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>217-07-1300</u>			17. INFORMANT <u>Hethur V. Davenport</u>		
18. CAUSE OF DEATH <u>575 X</u>			ADDRESS <u>530-E 27th St</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Liver failure</u> DUE TO, OR AS A CONSEQUENCE OF:		
			(B) <u>Chronic Sclerosing Cholangitis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>4 years</u>		
			(C) _____		
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Arthur P. Pangilinan M.D.</u>			23B. DATE SIGNED <u>10/29/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>ARTHUR P. PANGILINAN M.D.</u>			23D. ADDRESS <u>NORTH CHARLES GEN. HOSP.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-3-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Western Star</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Morton & Dyett</u>	
ADDRESS <u>1701 Hawthorne St</u>					

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10102	
CERTIFICATE OF DEATH					
BIRTH NO. 71 10102					
1. NAME OF DECEASED (Type or Print) <u>Lille Mae Rhone</u>			2. DATE AND HOUR OF DEATH <u>10/30/71</u> <u>2:00 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hospital</u>			A. STATE <u>Maryland</u> B. COUNTY <u>1702</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>501 Dolphin St. Apt 1102</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/31/98</u>	9. AGE (in years last birthday) <u>72</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Charlottesville, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Turk Rhone</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>005-10-7101-B</u>		17. INFORMANT <u>Russell Rhone - 501 - Dolphin St</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>10/27/71 + 250.9</u> <u>Post Exploratory Laparotomy and</u> <u>Roux en Y Cholecho-</u> <u>jejunostomy</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma Head of Pancreas</u> (B) <u>2 mo.</u> (C) <u>Diabetes Mellitis</u> <u>20 yrs.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>10/27/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Obstructive Jaundice</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/15</u> 19 <u>71</u> to <u>10/30</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/30</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. H. Ziegler M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10/30/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. H. Ziegler M.D.</u>		23D. ADDRESS <u>University of Maryland Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-2-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cemetery Baltimore, Md</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Moetere Dyett F.H. 101 - Lawrence</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLARENCE COOK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3133 E. Monument St. 2nd floor		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 25 1971 11:20 a.m.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 5/6/20		10. AGE (In years last birthday) 51	
11. BIRTHPLACE (State or foreign country) Balto, Md.		12. CITIZEN OF USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Daisey Jones		18. INFORMANT Mrs Elizabeth Heilman	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E9551		CAUSE OF DEATH Gunshot wound of head	
20A. DATE OF OPERATION 8		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour 10-25-71 3:10		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3133 E. Monument St.		22F. HOW DID INJURY OCCUR? Shot self.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) (HEAD ONLY)	
ACTUAL SIGNATURE Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/1/71	
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem		24D. LOCATION (City, town, or county) (State) Baltimore Balto Co Md	
25A. DATE REC'D BY HEALTH DEPT NOV 2 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Mc Culley F H Mt + Tink Neck Rd		ADDRESS Pasadena	

21 10102

21 10102



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

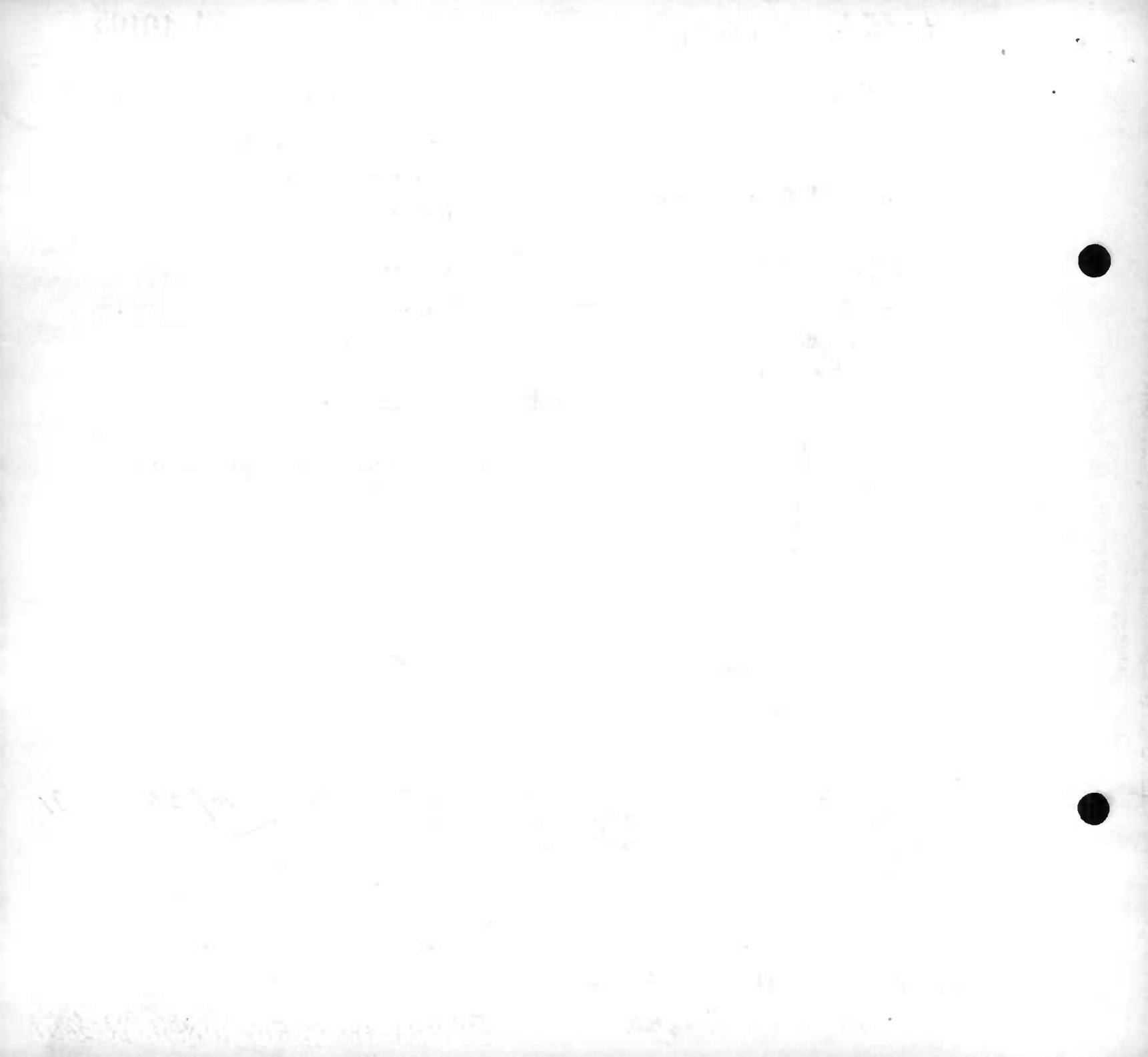
C-155 10104				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10104	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				HAROLD A. CHAPMAN		October 29, 1971 Between 4 and 5 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Md. 906			
00 2788 Tivoly Ave.				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2788 Tivoly Ave. 21213			
5. SEX Male		6. RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 31, 1905	
						9. AGE (In years last birthday) 66	
						If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yard Foreman				10B. KIND OF BUSINESS OR INDUSTRY Rail Road		11. BIRTHPLACE (State or foreign country) Anderson, Ind.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME CLYDE CHAPMAN				14. MOTHER'S MAIDEN NAME Ida Edith Swift			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1923-27				16. SOCIAL SECURITY NO. 558-10-6096		17. INFORMANT Mrs A. Clara Chapman 2788 Tivoly Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Occlusion</i>			
				(B) <i>arteriosclerotic cardiovascular disease with an old myocardial infarction</i>			
				(C) <i>gangrene</i>			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-28-58 19 to 10-29-71 19, that (I) (we) last saw the deceased alive on 10-22 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Eugene F. Nevy MD				23B. DATE SIGNED 10-31-71		23C. PHYSICIAN'S NAME (Type) Eugene F, Nevy MD	
23D. ADDRESS 7001 Mornington Road Dundalk, Md				23E. DATE SIGNED		23F. DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE Nov. 1, 71		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY	
24D. LOCATION Baltimore Co. Md.				24E. DATE SIGNED		24F. DATE SIGNED	
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971				25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR Ullrich Funeral Homes 4210 Belair Rd 21206	

W. C. F. 10101

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10105	
A-352 71 10105		CERTIFICATE OF DEATH	
BIRTH NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Adams, Theodore		10/26/71 9:10 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 49 N. Charles General Hosp.		Baltimore, Maryland C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore City YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 647 Gutman Avenue			
5. SEX male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01/18/07
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) janitor		10B. KIND OF BUSINESS OR INDUSTRY Penn Central	9. AGE (In years last birthday) 64
11. BIRTHPLACE (State or foreign country) So. Carolina		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Thomas Adams		14. MOTHER'S MAIDEN NAME Ivy Williams	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 249 03 4687	
17. INFORMANT Admission chart		ADDRESS	
18. 430X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary thrombo-emboli ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 10/26/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 10/17/71 to 10/26/71 that (1) (we) lost saw the deceased alive on 10/26/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Ruperto Manankil		23B. DATE SIGNED 10-26-71	
23C. PHYSICIAN'S NAME (Type) Ruperto Manankil		23D. ADDRESS N. Charles General Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-31-71	
24C. NAME of CEMETERY or CREMATORY CHURCH		24D. LOCATION (City, town, or county) (State) LANCASTER, So. C.	
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR JOHNSON & JENKINS FH.		ADDRESS 4804 GA. AVE. NW WASH. DC 20011	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10106	
<div style="display: flex; justify-content: space-between;"> 11-610 71 10106 CERTIFICATE OF DEATH </div>					
BIRTH NO. <u>Balto Co. Md.</u> 1. NAME OF DECEASED (Type or Print) <u>SHAWN MURPHY</u>			2. DATE AND HOUR OF DEATH <u>10/30/71</u> <u>10 30</u> <u>A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE 21220</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>409 GROVETHORN ROAD</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/23/71</u>	9. AGE (In years last birthday) <u>4</u>	10. Under 1 Yr. Months <u>6</u> Days <u>7</u> 11. Under 24 Hrs. Hours <u>7</u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md.</u>	
13. FATHER'S NAME <u>PATRICK MURPHY</u>			14. MOTHER'S MAIDEN NAME <u>SHARON WANIONK</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Patrick Murphy</u> <u>Same</u>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 MIN</u> <u>3 DAYS</u> <u>BIRTH</u>	
(A) IMMEDIATE CAUSE <u>CARDIORESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF:					
(B) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF:					
(C) TOTAL ANOMALOUS PULM VENOUS RETURN					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>11/2/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19 71</u> <u>to</u> <u>10/30</u> <u>19 71</u> that (I) (we) last saw the deceased alive on <u>10/30</u> <u>19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Basil John Zitelli</u> <u>M.D.</u> DEGREE				23B. DATE SIGNED <u>10/30/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>BASIL JOHN ZITELLI</u> DEGREE				23D. ADDRESS <u>The Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/2/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. J. ...</u>		25C. FUNERAL DIRECTOR <u>James E. Bruzdinski</u> ADDRESS <u>1407 Eastern Ave.</u>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10107</u>
BIRTH NO. <u>G-340</u> <u>10107</u>				
1. NAME OF DECEASED (Type or Print) <u>GOODWILL ANNA</u>		2. DATE AND HOUR OF DEATH <u>5³⁰ 04/30/71</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u> <u>BALTIMORE, MD 21205</u>		C. CITY OR TOWN <u>BALTIMORE 21224</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER <u>7915 BANK STREET</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>06-30-12</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		9. AGE (In years last birthday) <u>59</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>WILLIAM RUSSELL</u>		14. MOTHER'S MAIDEN NAME <u>MARY SCHLOTTER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-22-2829</u>		17. INFORMANT <u>Dennis Goodwill 783 Seaway Balto. Md.</u>
18. <u>693.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>RESPIRATORY + CARDIAC ARREST</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <u>Renal Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 MIN</u> <u>Many Years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White AI <input type="checkbox"/> Not White AI <input type="checkbox"/> Work <input type="checkbox"/> AI Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <u>Oct 26</u> 19 <u>71</u> to <u>Oct 30</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>Oct 30 5:40 AM</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Michael Karpf M.D.</u>		23B. DATE SIGNED <u>10/30/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>MICHAEL KARPf MD.</u>		23D. ADDRESS <u>JOHNS HOPKINS Hosp Balt. Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>11/2/71</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Jesus Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Jarboe, M.D.</u>		25C. FUNERAL DIRECTOR <u>Brudzinski Funeral Home</u>
				ADDRESS <u>1407 Eastern Ave.</u>



This certificate must be approved by the chief medical examiner's office if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>66-1228211 10108</u>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>71 10108</u>	
1. NAME OF DECEASED (Type or Print) <u>KIMBERLEY MADAIRY</u>				2. DATE AND HOUR OF DEATH <u>10/30/71</u> <u>1:40 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3708 HICKORY AVE</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>06-17-66</u>	9. AGE (In years last birthday) <u>5</u>	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>- -</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>- -</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>HARRY W. MADAIRY</u>				14. MOTHER'S MAIDEN NAME <u>PATRICIA WARREN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>- - -</u>			
17. INFORMANT <u>Patricia W. Madairy</u>				ADDRESS <u>3708 Hickory Ave</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>congenital heart disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>VENTRICULAR SEPTAL DEFECT</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 WKS</u> <u>24 HRS</u>			
19A. DATE OF OPERATION <u>10/29/71</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>VENTRICULAR SEPTAL DEFECT</u>			
20A. AUTOPSY? (Yes or No) <u>YES</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) <u>10/30/71</u>			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10/28</u> 19 <u>71</u> to <u>10/30</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/30/71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>James R. Reynolds</u>				23B. DATE SIGNED <u>10/30/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>JAMES R. REYNOLDS</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>11/2/71</u>			
24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 2 1971</u>				25B. NAME OF REGISTRAR <u>James E. Taylor, M.D.</u>			
25C. FUNERAL DIRECTOR <u>Donovan Funeral Home</u>				ADDRESS <u>3818 Roland Ave</u>			

X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Z-452 71 10109		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or print)		2. DATE AND HOUR OF DEATH	
Antonie (Antoinette) Zelenka		Oct. 31 1971 2:45 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
House In The Pines (Belvedere) 2525 W. Belvedere Ave		Md. 703	
5. SEX		6. RACE	
Female		White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4/19/90	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Seamstress		Czechoslovakia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Unknown		Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NO		214-20-3822	
17. INFORMANT		ADDRESS	
Edward Zelenka		3111 Gibbons Ave Balto Md 21214	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Undernourished Diet Co of Colon 2 months 20 yr exp.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) Cardiovascular & renal Bypass DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 29 1970 to Oct 31 1971 that (I) (we) last saw the deceased alive on Oct 31 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE	
Lester N. Kolman M.D.		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
LESTER N. KOLMAN, M.D.		6821 Reisterstown Rd. 21215 Balto Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		11/3/71	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Holy Redeemer		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
NOV 2 1971		Philip E. Grach	
25C. FUNERAL DIRECTOR		ADDRESS	
Philip E. Grach		1211 Chesaco Ave	

1. The first part of the report deals with the general situation of the country.

2. The second part deals with the economic situation of the country.

3. The third part deals with the social situation of the country.

4. The fourth part deals with the political situation of the country.

5. The fifth part deals with the cultural situation of the country.

6. The sixth part deals with the military situation of the country.

7. The seventh part deals with the foreign relations of the country.

8. The eighth part deals with the internal security of the country.

9. The ninth part deals with the public administration of the country.

10. The tenth part deals with the public health of the country.

11. The eleventh part deals with the public education of the country.

12. The twelfth part deals with the public works of the country.

13. The thirteenth part deals with the public finance of the country.

14. The fourteenth part deals with the public law of the country.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. A-520 71 10110		BALTIMORE CITY HEALTH DEPT. 71 10110	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
AMOS, JAMES MORSE		OCTOBER 30, 1971 10:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		A. STATE MARYLAND B. COUNTY Harford	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Forest Hill D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER BOX 166 MORSE ROAD 21050		F. STREET AND NUMBER	
5. SEX MALE		6. RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 02-12-00	
9. AGE (In years last birthday) 71		10. UNDER 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY Auto. Mechanic	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CORBIN AMOS		14. MOTHER'S MAIDEN NAME ELIZABETH MORSE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-01-1606	
17. INFORMANT T. Nelson Amos		Box ADDRESS 34	
18. 172.9 x 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic Malignant Melanoma		CAUSE OF DEATH 21084 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Malignant Melanoma	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes Mellitus - Arteriosclerosis		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21C. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		22. I certify that (I) (this hospital) attended the deceased from 10-01 19 71 to 10-30 19 71 that (I) (we) last saw the deceased alive on 10-30 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Miguel Karacuschansky M.D.		23B. DATE SIGNED 10-30-71	
23C. PHYSICIAN'S NAME (Type) Miguel KARACUSCHANSKY M.D.		23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/2/1971	
24C. NAME of CEMETERY or CREMATORY William Watters		24D. LOCATION (City, town, or county) (State) Jarrettsville, Harford, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 2 1971		25B. NAME OF REGISTRAR Charles E. Kurtz	
25C. FUNERAL DIRECTOR Charles E. Kurtz		ADDRESS Jarrettsville, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-623 71 10111		ORE CITY HEALTH DEPARTMENT		REG. NO. 71 10111	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Frank Krestbaum		2. DATE AND HOUR OF DEATH 10/30/71 4 ⁴⁵ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland B. COUNTY 2608	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 335 S. Conkling Street		21224	
5. SEX M	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-28-10	9. AGE (In years last birthday) 61	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Frank		14. MOTHER'S MAIDEN NAME Anna			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) F 12.5		16. SOCIAL SECURITY NO. 078-07-8141		17. INFORMANT BCH RECORDS: 4940 Eastern Avenue Baltimore, Maryland 21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Tension Pneumothorax pulmonary arrest 20 Intubation Pulmonary Edema ASCVD & CHF 12 hrs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (a) (this hospital) attended the deceased from 10/30 19 71 to 10/30 19 71 that (b) (we) last saw the deceased alive on 10/30 19 71 and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James Franklin Grim MD		23B. DATE SIGNED 10/30/71		23C. PHYSICIAN'S NAME (Type) James Franklin Grim MD	
23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/3/71		24C. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971		25B. NAME OF REGISTRAR Robert E. Fisher MD		25C. FUNERAL DIRECTOR Joseph N. Zannino - 263 S. Conkling St.	

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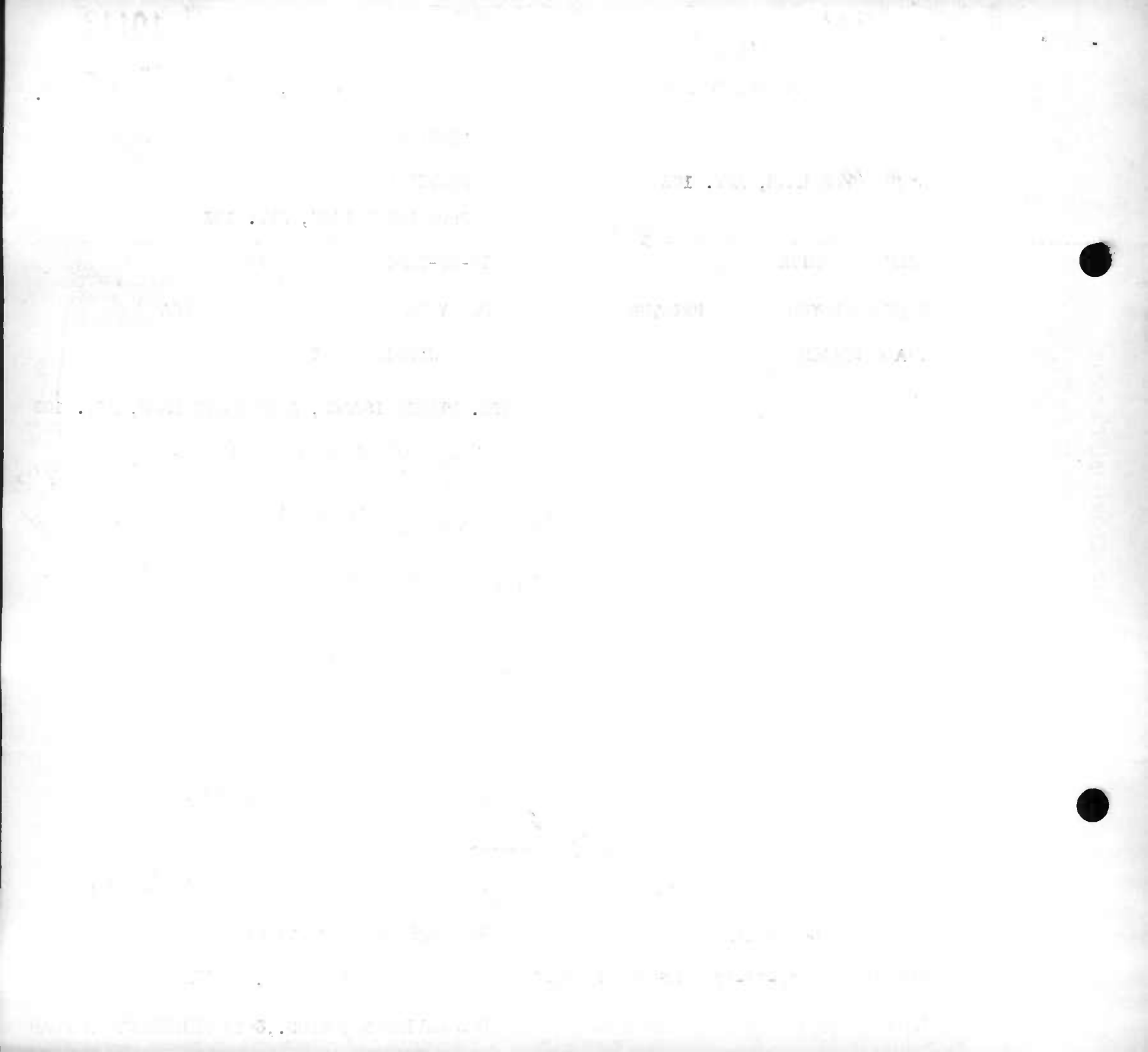
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 10112	
CERTIFICATE OF DEATH				REG. NO. 71 10112	
BIRTH NO. 71 10112		1. NAME OF DECEASED (Type or Print) SAMUEL ISAACS			
2. DATE AND HOUR OF DEATH		OCTOBER 28, 1971 10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND			
3900 FORDS LANE, APT. 103		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10-23-1892		9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ISAAC ISAACS	
14. MOTHER'S MAIDEN NAME JENNIE ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS MRS. MINNIE ISAACS, 3900 FORDS LANE, APT. 103			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Tumor of Kidney, Malignant			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastases to many bones			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension of Arteries			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) 1971 Sept			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 9/15/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED enlarged prostate		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1967 to 10/28/71 that (I) (we) last saw the deceased alive on 10/28/71 and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE SOL Smith		23B. DATE SIGNED 10/29/71		23C. PHYSICIAN'S NAME (Type) SOL SMITH	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-31-71		24C. NAME of CEMETERY or CREMATORY HEBREW FRIENDSHIP	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25D. ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 10113
BIRTH NO. B-620 71 10113		1. NAME OF DECEASED (Type or Print) BELLA BORACK		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH NOV 1, 1971 7 45 P M.		
FULL NAME OF HOSPITAL OR INSTITUTION 90 JEWISH CONVALESCENT HOME		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3931 SOUTHERN CROSS DRIVE #21207		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 1, 1888	9. AGE (In years last birthday) 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) POLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME BERYL BUCKBINDER		
14. MOTHER'S MAIDEN NAME IRAZEL ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. ANN STRAUSS, 3651 PASKIN PL., APT. 201		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 41231-250.9 (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) BRONCHO-PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Week.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease 4 years (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Diabetes mellitus 5 years		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from March 22 1971 to Nov 1 1971 , that (I) (we) last saw the deceased alive on Nov 1 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Manuel Levin M.D.		23B. DATE SIGNED 11/1/71		23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN
23D. ADDRESS M.D. 6101 PARK HIGTS AVE. BALTO-15 MD		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 11-2-71	24C. NAME OF CEMETERY or CREMATORY RUDOMER VEREIN	24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971	25B. NAME OF REGISTRAR Robert E. Taylor M.D.	25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>S-500 71 10114</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 10114</u>	
1. NAME OF DECEASED (Type or Print) <u>Morris L. Shane</u>		2. DATE AND HOUR OF DEATH <u>Sun Oct 31/71</u> <u>1:40</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hosp.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Ind.</u> B. COUNTY <u>2740</u>	
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>6315 Race Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 11, 1915</u>	9. AGE (in years last birthday) <u>56</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>		11. BIRTHPLACE (State or foreign country) <u>Balto, Ind</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Philip Shane</u>		14. MOTHER'S MAIDEN NAME <u>Mary -</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-01-6593</u>		17. INFORMANT <u>Mrs Edythe Shane - Same</u>	
18. <u>410.0 I</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Thrombosis</u>		<u>minutes</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>(14 Coronary 8 years go)</u>		<u>?</u>	
		(C) <u>Hypertension</u>		<u>15 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19 60</u> to <u>Oct</u> <u>19 71</u> that (I) (we) last saw the deceased alive on <u>Oct 25</u> <u>19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>E. Lisansky M.D.</u>				23B. DATE SIGNED <u>Nov 1/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>EPHRAIM LISANSKY</u>		23D. ADDRESS <u>6804 Park Heights Ave</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/1/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Beth Shalom</u>	
24D. LOCATION <u>Balto, Ind.</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 3 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>6010 Reisterstown Rd.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 10115	
CERTIFICATE OF DEATH				Registered No.	
1. NAME OF DECEASED (Type or Print) MYRNA LAZAR		2. DATE AND HOUR OF DEATH OCTOBER 29, 1971 11:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL HOSPITAL		A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5606 NORTHGREEN RD.			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-17-37	9. AGE (In years last birthday) 34	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME MAX LEDERMAN			
14. MOTHER'S MAIDEN NAME ROSE SCHAPIRO		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT JACK LAZAR ADDRESS 5606 NORTHGREEN RD.			
18. 200001 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) CNS INVASION (B) RETICULUM CELL SARCOMA (C)			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCT. 29 19 71 to OCT. 29 19 71, that (I) (we) last saw the deceased alive on OCT. 29 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard H. Balcer M.D.				23B. DATE SIGNED OCT. 29, 1971	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS MARYLAND GENERAL HOSPITAL M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-31-71		24C. NAME of CEMETERY or CREMATORY MIKRO KODESH	
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

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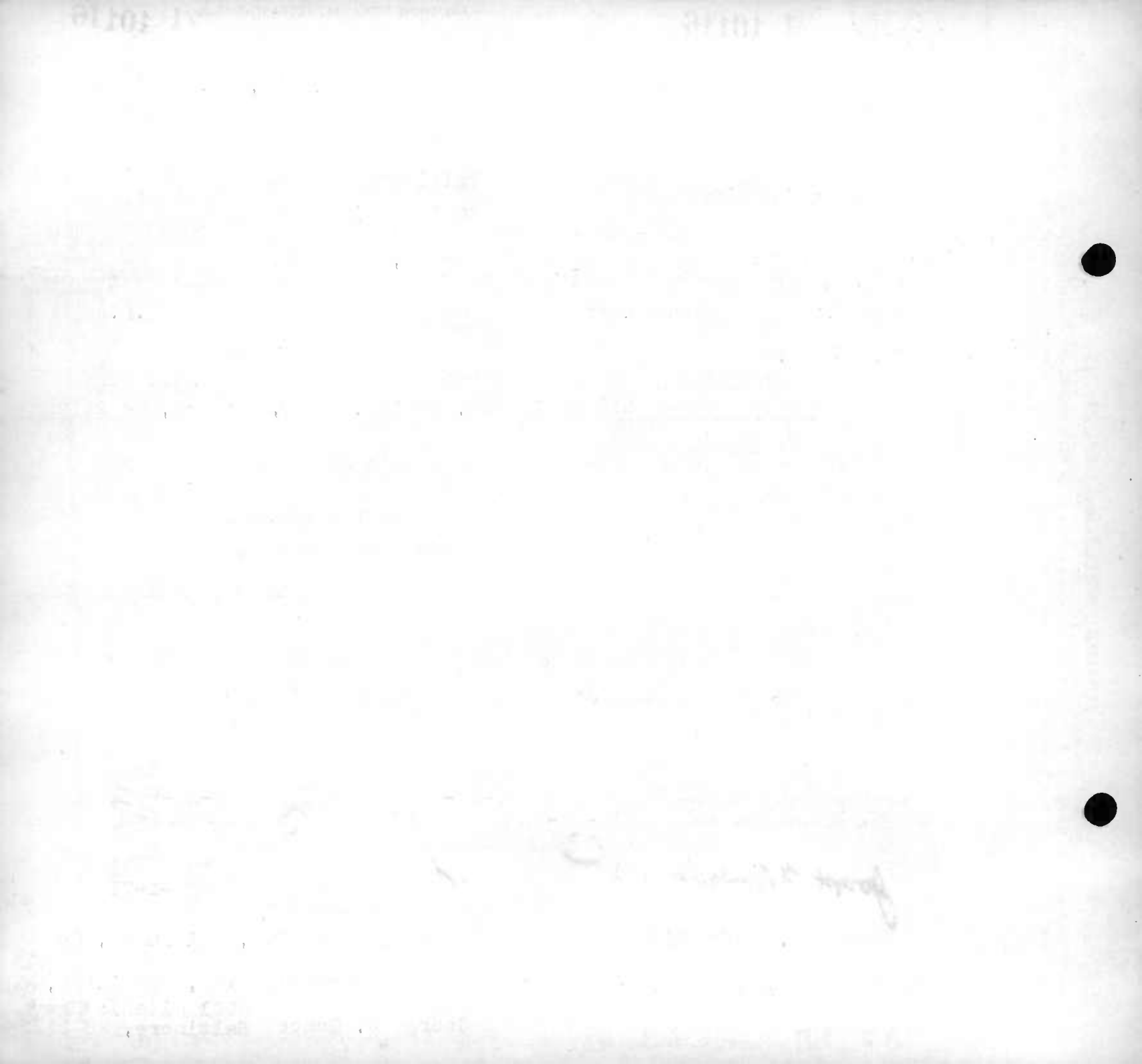
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FUNERAL DIRECTOR: IMPORTANT

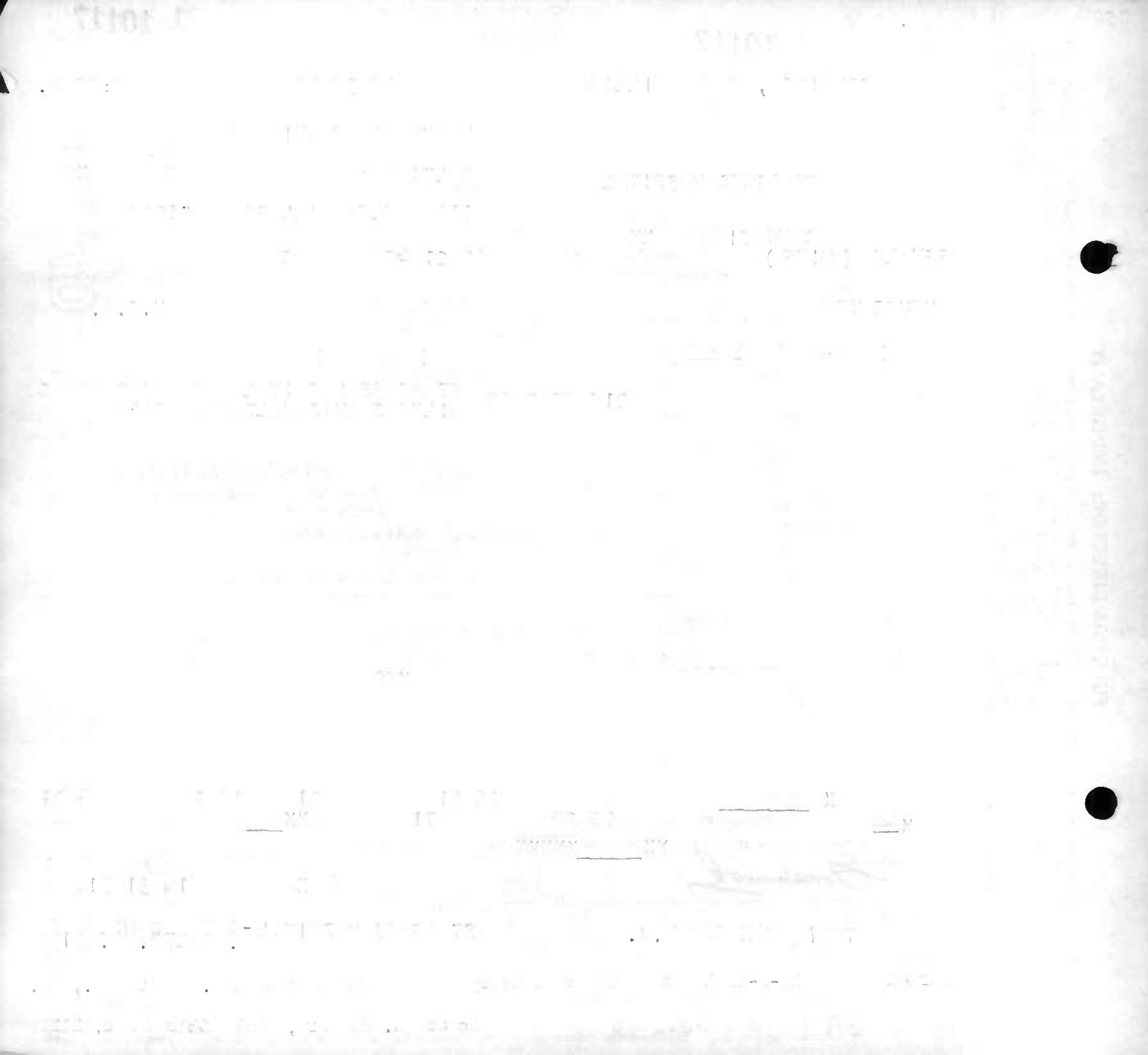
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
REG. NO. 71 10116									
<div style="display: flex; justify-content: space-between;"> <div> <p>K-430 71 10116</p> <p>BIRTH NO.</p> </div> <div> <p>1. NAME OF DECEASED (Type or Print) Genevieve Pauline Klatt</p> </div> <div> <p>2. DATE AND HOUR OF DEATH October 30, 1971 6:30 P.M.</p> </div> </div>									
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital</p>					<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Maryland B. COUNTY 2632</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 5021 Belair Road</p>				
<p>5. SEX Female</p>		<p>6. RACE White</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH July 12, 1890</p>		<p>9. AGE (In years last birthday) 81</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>				<p>10B. KIND OF BUSINESS OR INDUSTRY Homemaker</p>		<p>11. BIRTHPLACE (State or foreign country) Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A</p>	
<p>13. FATHER'S NAME Frank Deppish</p>					<p>14. MOTHER'S MAIDEN NAME Quigley</p>				
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>				<p>16. SOCIAL SECURITY NO. 212 07 3958</p>		<p>17. INFORMANT Mr. Paul E. Klatt ADDRESS 253 Harlem Road Pasadena, Md 21122</p>			
<p>18. 41251 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arterio Sclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cardio Vascular Disease</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio Vascular Disease</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>									
<p>19A. DATE OF OPERATION 9-10-71</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>			
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>			<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>			<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>			<p>21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/></p>			<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from 9-10-71 to 10-30-71 and that (I) (we) last saw the deceased alive on 10-30-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>									
<p>23A. SIGNATURE <i>Joseph G. Laukaitis</i></p>								<p>23B. DATE SIGNED 11-1-71</p>	
<p>23C. PHYSICIAN'S NAME (Type) Joseph G. Laukaitis</p>								<p>23D. ADDRESS 679 Washington Blvd, Baltimore, Md</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 11/2/71</p>		<p>24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State) Frederick Ave, Baltimore, Md</p>			
<p>25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971</p>			<p>25B. NAME OF REGISTRAR George J. Gonce</p>			<p>25C. FUNERAL DIRECTOR ADDRESS 4001 Ritchie Hwy Baltimore, Md 21225</p>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>71 10117</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH <u>X</u> REG. NO. <u>71 10117</u>	
1. NAME OF DECEASED (Type or Print) <u>SCHRIVER, EMMA PHILLIPS</u>		2. DATE AND HOUR OF DEATH <u>10 30 71</u> <u>5:30 P. M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST AGNES HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>111 OAKLEE VILLAGE 21229</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>CAUCASIAN (WHITE)</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 21 1886</u> 9. AGE (in years lost birthday) <u>84</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(Unknown) Phillips</u>		14. MOTHER'S MAIDEN NAME <u>(Unknown)</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215 05 3800</u> 17. INFORMANT ADDRESS <u>ST AGNES HOSPITAL RECORDS CATON & WILKENS AVES BALTO MD 21229</u>	
18. <u>410.915-121.2</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>CORONARY ATHEROSCLEROSIS WITH COMPLETE OCCLUSION OF LEFT ANTERIOR DESCENDING CORONARY ARTERY</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalized atherosclerosis</u> <u>PULMONARY CONGESTION AND EDEMA-ACUTE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>LIPOSARCOMA, RIGHT ARM, WITH PERITUMORAL METASTASES.</u>			
19A. DATE OF OPERATION <u>10 30 71</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>YES</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>10 21 19 71</u> to <u>10 30 19 71</u> that <u>(I)</u> (we) last saw the deceased alive on <u>10 30 19 71</u> and that in <u>(XX)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) <u>(XXXX)</u> view the body after death.			
23A. SIGNATURE <u>Tariq Mahmood</u>		23B. DATE SIGNED <u>10 31 71</u>	
23C. PHYSICIAN'S NAME (Type) <u>TARIQ MAHMOOD M.D.</u>		23D. ADDRESS <u>ST AGNES HOSPITAL - CATON & WILKENS AVES. BALTO. MD. 21229</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>11-3-1971</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Washington Blvd. Howard Co., Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 3 1971</u>	25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>	25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-536 71 10118				BALTIMORE CITY HEALTH DEPT.		X CERTIFICATE OF DEATH		71 10118	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				BENDER, GEORGE CHRISTIAN		10 30 71		10:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		BALTIMORE	
				C. CITY OR TOWN		CATONSVILLE		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER		1202 TUGWELL DR BALTO MD		21228	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE		CAUCASIAN		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11 12 81		89	
								If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired Gen. Mgr.				Welsbach Corp.		MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
GEORGE BENDER				(Unknown)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO				215 05 9187		ST AGNES HOSPITAL RECORDS CATON & WILKENS AVES BALTO MD 21229			
18. 5 21 91				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
				Arrhythmia and Pump Failure					
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Complete Heart Block					
				Pulmonary Edema					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
				old Cirrhosis of Liver					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that XX (this hospital) attended the deceased from 10 29 19 71 to 10 30 19 71 that X (we) last saw the deceased alive on 10 30 19 71 and that in (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) XXX view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
				10 31 71					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
TARIQ MAHMOOD M.D.				WILKENS AVES. BALTO., MD. 21229		ST AGNES HOSPITAL		- CATON &	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		11-3-1971		Loudon Park Cemetery		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
NOV 3 1971		Robert E. Taylor, M.D.		Howard H. Hubbard, 4107 Wilkens Ave. 21229					

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1		71 10119		BALTIMORE CITY HEALTH DEPARTMENT		71 10119	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.			
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) THEODORE WILLIAMS				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1016 N. Calvert Street				3. DATE PRONOUNCED DEAD Month Day Year Hour October 26, 1971 4:55 P.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1101							
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1915		10. AGE (In years last birthday) 55		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN G. WILLIAMS		14. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOCIAL WORKER		14B. KIND OF BUSINESS OR INDUSTRY BALTO. CITY		15. MOTHER'S MAIDEN NAME DELL K. SAMPLE	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		17. SOCIAL SECURITY NO.		18. INFORMANT GEORGE MANDRAS 428 S. NEWKIRK STREET		ADDRESS	
19. E 9 5 5 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. DATE OF OPERATION 2				21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1016 N. Calvert Street 1101				22D. TIME OF INJURY (Month) (Day) (Year) (Hour) October 1971 ? m.			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Self-inflicted			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION				24B. DATE 11-1-71			
24C. NAME OF CEMETERY or CREMATORY GREENMOUNT CEMETERY				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971				25B. NAME OF REGISTRAR 260 E. 32nd St.			
25C. FUNERAL DIRECTOR Nicholas T. MATTHEWS				ADDRESS 3021 EASTERN AVE 21224			

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William B. Williams

Bill A. Sample

11-11-11

M-242 ⁷¹ 10120 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH ⁷¹ 10120
 REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Michael J. McLaughlin		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 11 2 71 7:00A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 3400 Annapolis Rd.		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 2 71 7:00A. M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1803	
6. SEX Male	7. RACE White	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 12/31/1904		10. AGE (In years lost birthday) 66		E. STREET AND NUMBER 37 S. Arlington Avenue	
11. BIRTHPLACE (State or foreign country) Beth. Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME McLaughlin	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		14B. KIND OF BUSINESS OR INDUSTRY self-employed		15. MOTHER'S MAIDEN NAME Josephine Brown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. -		18. INFORMANT Marie Runkles 3001 Delaware Ave. 21227	
19. 4124 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 11/5/71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE OF EXAMINER Werner U. Spitz, M.D. M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11-2-71					
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 11/5/71		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) G.A. Co. Ind.		25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971		25B. NAME OF REGISTRAR Robert E. Farber, R.D.	
25C. FUNERAL DIRECTOR John F. Coverdale Inc.		25D. ADDRESS 901 Hollins St. Beth Ind. 21223			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 21 10121	
CERTIFICATE OF DEATH											
BIRTH NO. 10121					1. NAME OF DECEASED (Type or Print) DAVIS, CLARENCE JOHN					2. DATE AND HOUR OF DEATH OCTOBER 29, 1971 4:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY HOWARD					6300	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVE					C. CITY OR TOWN ELIHUT CITY					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 5010 AVOCA AVENUE					21043						
5. SEX MALE		6. RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 28 88		9. AGE (In years last birthday) 83		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) OHIO	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME CLARENCE DAVIS					14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN					16. SOCIAL SECURITY NO. 298-14-6774A		17. INFORMANT BALTIMORE, MARYLAND 21229 ST AGNES HOSPITAL CATON & WILKENS AVE				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF: Chronic Bronchitis, Emphysema (B) DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia (C) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from OCTOBER 28 19 71 to OCTOBER 29 1971 that (X) (we) last saw the deceased alive on OCTOBER 29 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.											
23A. SIGNATURE M. YOUSUF SIDDIQUI DEGREE								23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) M. YOUSUF SIDDIQUI, MD DEGREE	
23D. ADDRESS E.								23E. ADDRESS		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 11-1-71				24C. NAME OF CEMETERY OR CREMATORY GLEN VIEW			
24D. LOCATION E. PALESTINE OHIO				24E. LOCATION (City, town, or county) (State)				24F. LOCATION			
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971				25B. NAME OF REGISTRAR Valdez, R.D.				25C. FUNERAL DIRECTOR Higinbotham, Jack			
25D. ADDRESS				25E. ADDRESS				25F. ADDRESS			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 10122</u>	
<div style="display: flex; justify-content: space-between;"> S-530 71 10122 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <u>Mary E. Smith</u>		2. DATE AND HOUR OF DEATH <u>10 - 30 - 1971</u> <u>13:05 p. m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00 1601 South Charles Street</u>		A. STATE <u>Md.</u>		B. COUNTY <u>2302</u>	
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1601 South Charles Street</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 29, 1902</u>	9. AGE (in years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Hugh Flemister</u>			
14. MOTHER'S MAIDEN NAME <u>Sarah (Clardy)</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. William Smith - same as # 4</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Adenocarcinoma of uterus</u> <u>2 pulmonary metastases</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 yrs.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>Hypertensive Cardiovascular disease</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>3-8-1963</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>same</u>		20A. AUTOPSY? (Yes or No) <u>no</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>no</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>no</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>no</u>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> <u>no</u>		21F. HOW DID INJURY OCCUR? <u>no</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>March 6 1956</u> to <u>October 30 1971</u> that (I) was last saw the deceased alive on <u>October 30 1971</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.					
23A. SIGNATURE <u>C. C. CHILU, M.D.</u>		23B. DATE SIGNED <u>11-1-71</u>			
23C. PHYSICIAN'S NAME (Type) <u>C. C. CHILU, M.D.</u>		23D. ADDRESS <u>1 E. Randall St. Baltimore Md. 21230</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-3-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l. Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 3 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, R.D.</u>		25C. FUNERAL DIRECTOR <u>Mc Cully - 130 E. Fort Ave. City 21230</u>	

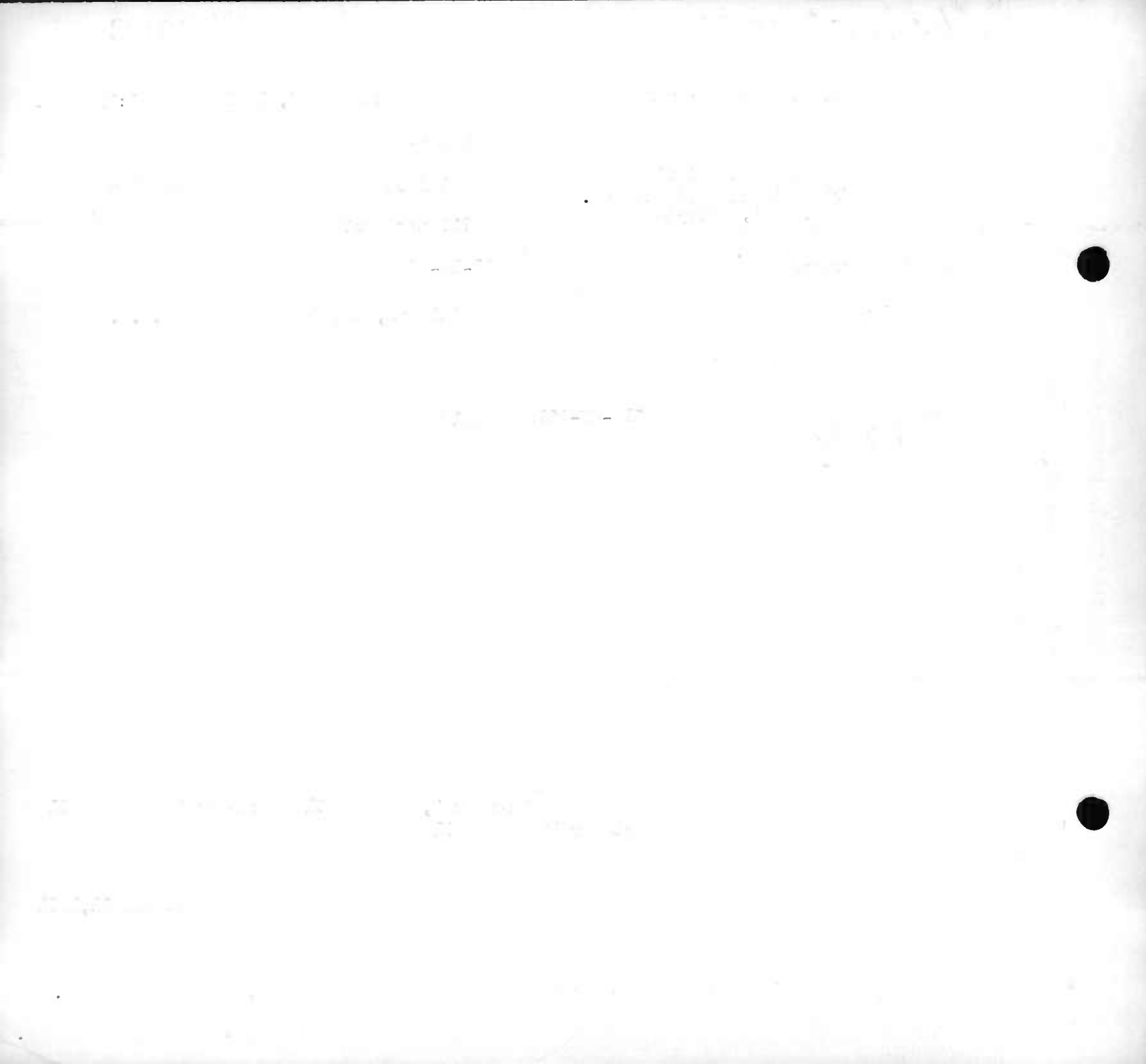
Hydrogen Cyanide

March 6 1891
C. C. CHIL. M.D. 15 Russell St Boston Mass
✓

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10123	
<div style="display: flex; justify-content: space-between;"> G-615-71 10123 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)			
		Griffin Susan Dorothy			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH			
FULL NAME OF HOSPITAL OR INSTITUTION 39		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital 2600 Liberty Heights Ave. Baltimore, Md		October 30, 1971 2:25 PM.	
5. SEX Female		6. RACE Cauc. Negro		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1301	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11-19-86		9. AGE (In years last birthday) 85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Charles Griffin		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-05-4275		17. INFORMANT Self	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Septicemia DUE TO, OR AS A CONSEQUENCE OF: (B) skin ulcers, Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (C) CHF, GI bleeding		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 hours 1 week	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>October 2,</u> 19 <u>71</u> to <u>October 30</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>October 30</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. J. Shafi</u>				23B. DATE SIGNED October 31, 1971	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
SHAFI		R. Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/3/71		Loudon Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 3 1971		Robert E. Taber, M.D.		Donovan Funeral Home-3818 Roland Ave.	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
Baltimore,		Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10124</u>	
BIRTH NO. <u>4-200 71 10124</u>		2. DATE AND HOUR OF DEATH <u>OCTOBER 31, 1971</u> <u>5:00</u> A.M.			
1. NAME OF DECEASED (Type or Print) <u>HICKS, DAWN MARIE</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>40 ST AGNES HOSPITAL</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST AGNES HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		C. CITY OR TOWN <u>Woodlawn</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>FEMALE</u>		6. RACE <u>CAUCASIAN</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>06 02 64</u>		9. AGE (In years last birthday) <u>7</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>			
13. FATHER'S NAME <u>ROGER HICKS</u>		14. MOTHER'S MAIDEN NAME <u>PATRICIA (WHITE)</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS <u>ST AGNES RECORDS BALTO MD 21229</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Atelectasis of both lungs</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hydrocephalus, chronic, massive years</u>			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 28</u> 19 <u>71</u> to <u>OCTOBER 31</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>OCTOBER 31</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lili L. de Borja M.D.</u>		23B. DATE SIGNED <u>10-31-71</u>		23C. PHYSICIAN'S NAME (Type) <u>Lili L. de Borja M.D.</u>	
23D. ADDRESS <u>St. Agnes Hosp.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>11/2/1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 3 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>8728 Liberty Rd</u> ADDRESS <u>21133</u> <u>Loring B. B. Funeral Directors, P.C.</u>	

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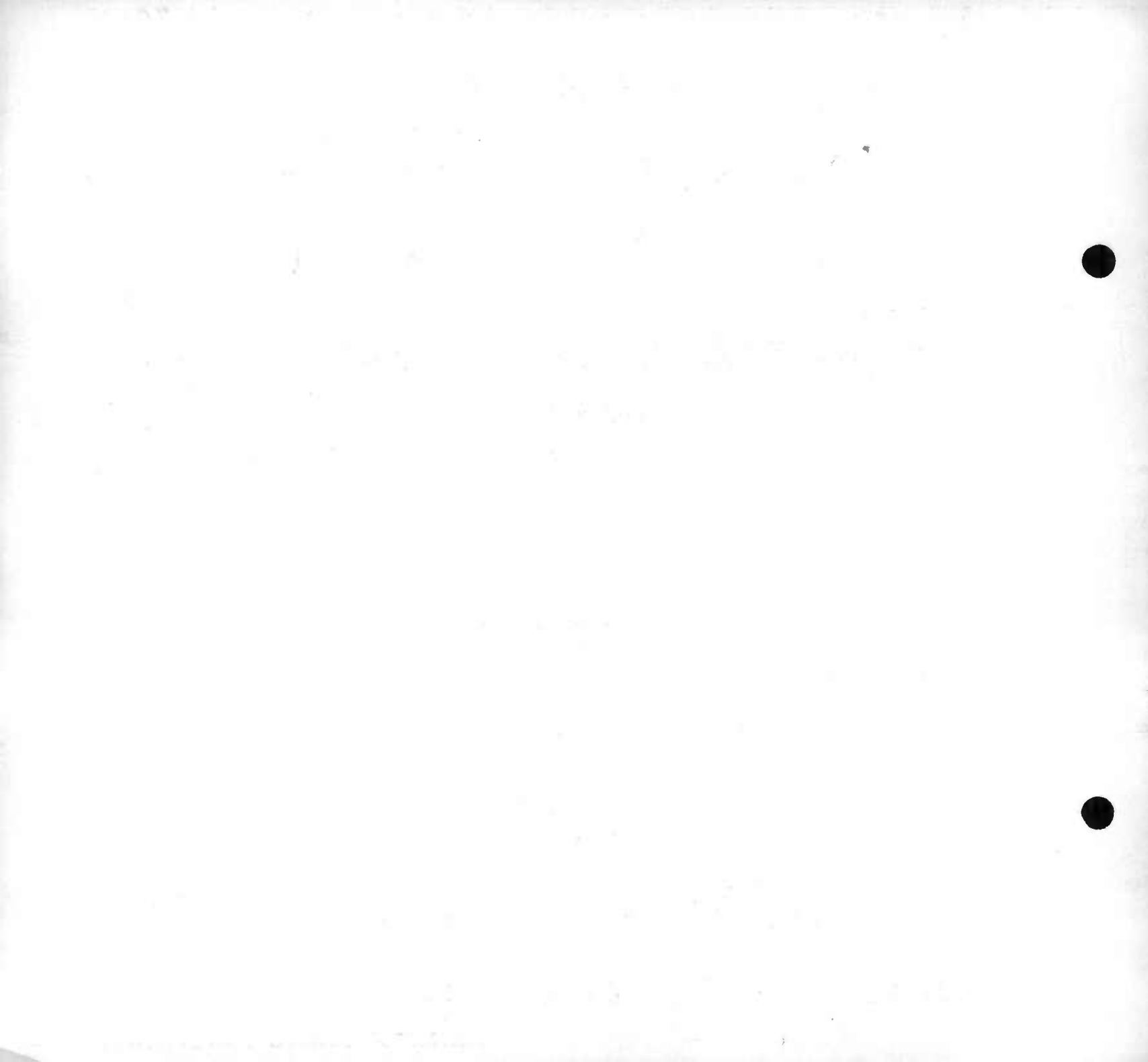
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO.	
V-230 71 10125		71 10125			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
VEST MRS ANGELA F.		10/31/71 11:30 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Md. General Hosp. Tol		A. STATE 2022 Longview Ct. 5300			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore 21237		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER					
5. SEX Female	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-6-35	9. AGE (in years last birthday) 36	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY USA					
13. FATHER'S NAME Joseph F. Chalmers		14. MOTHER'S MAIDEN NAME Catherine Espey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 229-42-2933		17. INFORMANT James Vest 2022 Longview Ct.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Acute Pulmonary edema and congestion (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Post operation, megacolon (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hr 2 wk	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Gastric Ulcer Esophageal					
19A. DATE OF OPERATION 10/18/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED good		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/18/1971 to 10/31/1971 that (I) (we) last saw the deceased alive on 10/31/71 7/ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D. S. S. S. S.		23B. DATE SIGNED 10/31/71			
23C. PHYSICIAN'S NAME (Type) SONACHAROV		23D. ADDRESS Md. General Hosp. Tol			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/4/71		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith	
24D. LOCATION Balto Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Philip F. Givach 1211 Chesaco Ave	



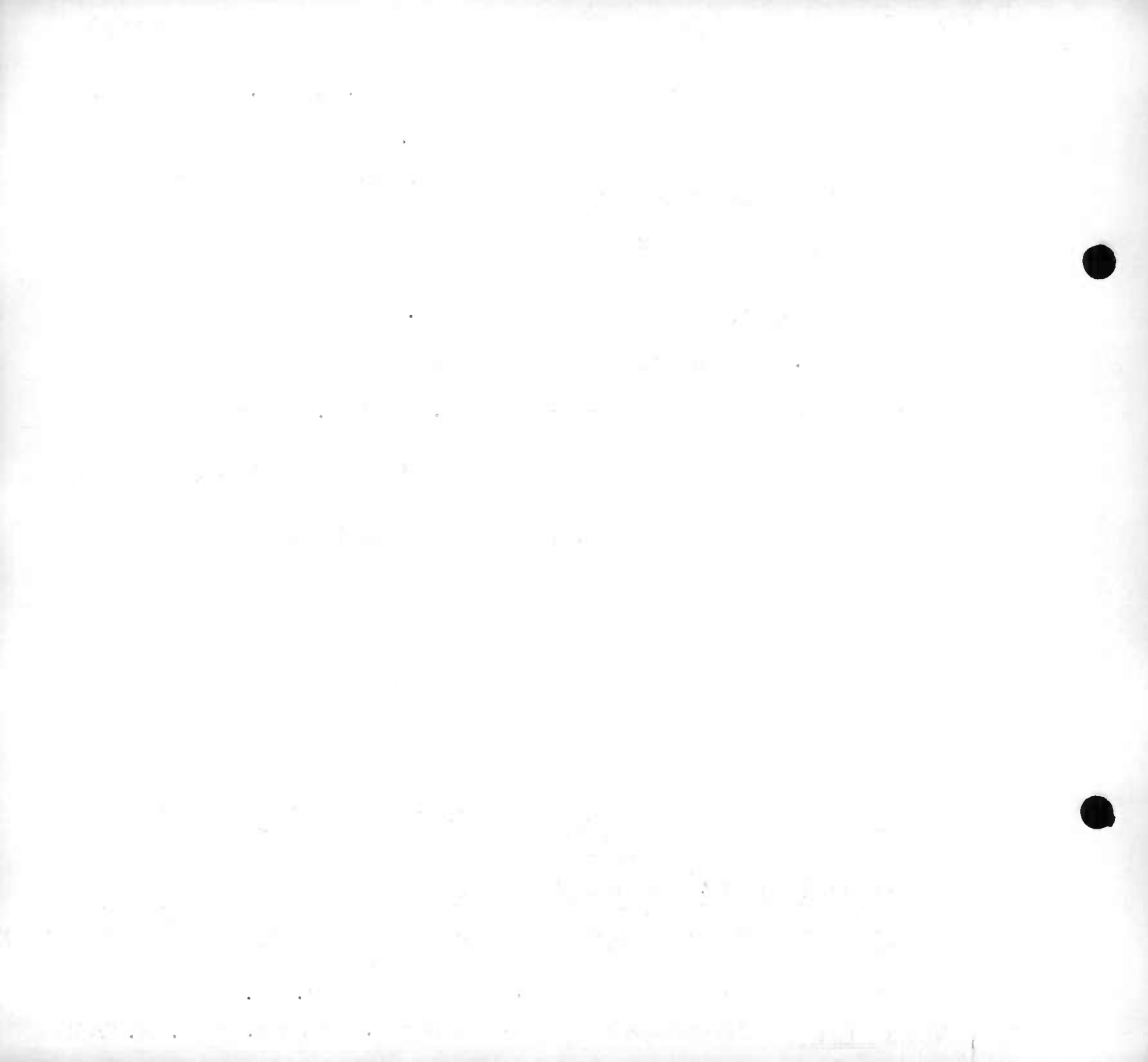
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-450 71 10126		BALTIMORE CITY HEALTH DEPARTMENT		71 10126	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		JAMES WINFIELD BLANEY		2. DATE AND HOUR OF DEATH Oct 30, 1971 2:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE MD. BALTO	
FULL NAME OF HOSPITAL OR INSTITUTION AS IN #4 4012 Walnut Avenue		C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 8/7/1903	
MECHANIC		AUTO		9. AGE (in years last birthday) 68	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
BALTO. MD		U.S.A.			
13. FATHER'S NAME STILLWELL BLANEY		14. MOTHER'S MAIDEN NAME ANNIE RAMPLEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-01-3090		17. INFORMANT GLADYS BLANEY (WIFE) address above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE EMPHYSEMA.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN. 5 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>None</u> to <u>Oct 30</u> 19 <u>71</u> . that (I) (we) last saw the deceased alive on <u>Oct 30</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE Louis N. Towlin M.D.		23B. DATE SIGNED 10/31/71	
23C. PHYSICIAN'S NAME (Type) LOUIS N. TOWLIN M.D.		23D. ADDRESS 6908 N. 8th Rd BALTO MD. 21219			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		11-2-71		Holy Cross Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 3 1971		Robert E. Talley, R.D.		Lassahn Funeral Home 7401 Belair Rd. Bato.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

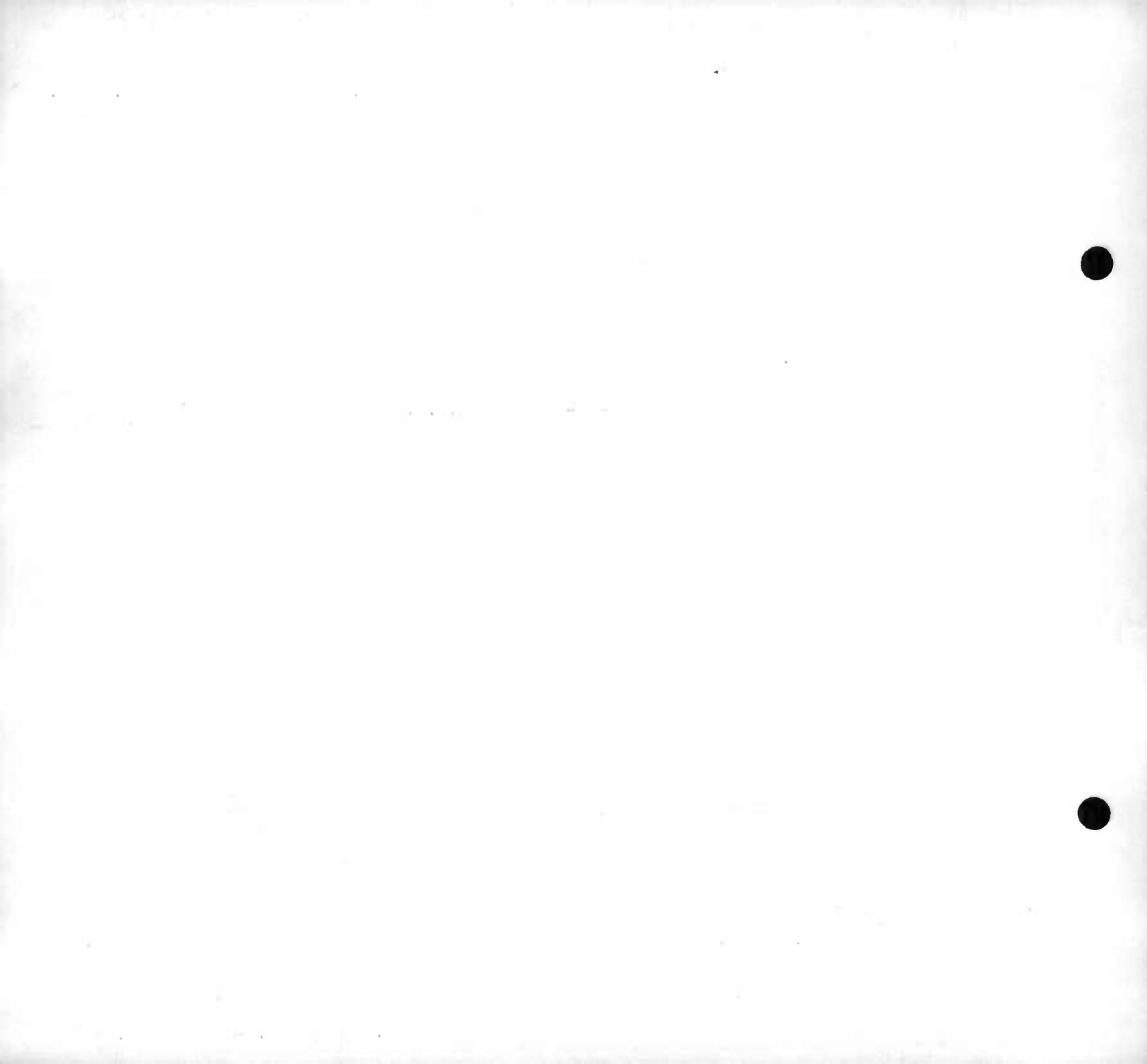
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10127	
BIRTH NO. B-521 71 10127				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ALFRED E. BONGIOVANNI			2. DATE AND HOUR OF DEATH NOV. 2, 1971. 4:35am M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2632		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4726 Homedale Avenue		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/1929	9. AGE (In years last birthday) 42	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automotive Electrician			11. BIRTHPLACE (State or foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Emanuel V. Bongiovanni			14. MOTHER'S MAIDEN NAME Carmelena Santoro		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes. Korea			16. SOCIAL SECURITY NO. 212-34-7654		
			17. INFORMANT ADDRESS Mrs. Betty J. Bongiovanni same		
18. 41019 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION (B) CORONARY ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 1 yr.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/16 1920 to 10/31 1971 that (I) (we) last saw the deceased alive on 10/31/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.					
23A. SIGNATURE STUART D. SUNDAY				23B. DATE SIGNED 11/2/71	
23C. PHYSICIAN'S NAME (Type) STUART D. SUNDAY				23D. ADDRESS 201 E. 33rd ST. BALTO. MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/4/71		24C. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk	
				24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971		25B. NAME OF REGISTRAR Robert E. Taber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530 71 10128		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 71 10128	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MILDRED APGAR SMITH		2. DATE AND HOUR OF DEATH Oct. 31, 1971 11.35 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO		5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 90 HARFORD GARDENS CONVALESCENT HOME		E. STREET AND NUMBER 1314 Highland Drive			
5. SEX female	6. RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1896	9. AGE (in years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) beautician: retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Martin B. Apgar		14. MOTHER'S MAIDEN NAME Iulia Kompher	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 277-18-0762		17. INFORMANT Mrs. W.P. Primm ADDRESS 10399 67th Ave. N, Lot #27 Edgewater Pines Mbl. Home,	
18. 436.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Several strokes		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Generalized Atherosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several years	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1968 to Oct. 31 71 and that (I) (we) last saw the deceased alive on Oct. 30 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Loy M. Zimmerman		23B. DATE SIGNED 11/1/71		23C. PHYSICIAN'S NAME (Type) Dr. Loy M. Zimmerman	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 11/ /71		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		25D. ADDRESS Balto, Md. - 14			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10129	
C-545 71 10129				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CONLON, THOMAS EDWARD JR		10/31/71 10:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			A. STATE Maryland B. COUNTY 2747		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2410 Fleetwood Avenue		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/14/11	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pittsburg, Pa	
13. FATHER'S NAME Thomas E Conlon Sr.		14. MOTHER'S MAIDEN NAME Marcella Quigley		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) YES		16. SOCIAL SECURITY NO. 12/23/43 - 12/10/45 212-10-3378		17. INFORMANT VA Hospital Records 3900 Loch Raven Boulevard Balto., Md 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 410.9 I DISEASE OF CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/31 1971 to 10/31/71 1971, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/31/ 1971 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <i>Robert E. Sharrock</i>			23B. DATE SIGNED 11/1/71		
23C. PHYSICIAN'S NAME (Type) ROBERT E. SHARROCK, M.D.			23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/4/71		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. NOV 3 1971		24F. NAME OF REGISTRAR Robert E. Fisher, M.D.	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto., Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10130	
P-620 71 10130				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) SIDNEY PRICE		2. DATE AND HOUR OF DEATH Nov. 1, 1971 1:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1701			
FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home & Hospital		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 622 N. Euterne St.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/28/01	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) 10 MD	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Sidney Price		14. MOTHER'S MAIDEN NAME Laura Mae Hurdley	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 012-14-1102		17. INFORMANT pt. ADDRESS	
18. 162.1 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiomyopathy failure			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Aspirin pneumonia CHF DUE TO, OR AS A CONSEQUENCE OF:		5 days approx	
(C) possible Luz pathology					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 10/20 19 71 to 11/1 19 71 that (I) (we) last saw the deceased alive on 11/1 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Germa P. Indolos MD		23B. DATE SIGNED Nov. 1, 1971		23C. PHYSICIAN'S NAME (Type) GERMA P. INDOLOS MD	
23D. ADDRESS Church Home & Hosp.		24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 11/5/71	
24C. NAME of CEMETERY or CREMATORY Linden Park Cemetery Balto. Md		24D. LOCATION (City, town or county) (State) Balto. Md		25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971	
25B. NAME of REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR Williams Funeral Home 3199 Woodrow		25D. ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10131</u>	
BIRTH NO. <u>71 10131</u>		1. NAME OF DECEASED (Type or Print) <u>Henry Owens</u>		2. DATE AND HOUR OF DEATH <u>11/1/71</u> <u>5:10 PM.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1504</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bolton Hill Nrsg Home</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2136 Walbrook Ave #17</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-4-84</u>	9. AGE (In years last birthday) <u>86</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>Anderson Owens</u>			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Marcho Doyton</u> <u>2136 Walbrook Ave Baltimore</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last. <u>AS. C. V. Disease</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Sensitivity. Chr. Brain Syndrome?</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10/21/71</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/21</u> 19 <u>71</u> to <u>11/1/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/21</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph S. Blum</u>				23B. DATE SIGNED <u>11/2/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM M.D.</u>				23D. ADDRESS <u>1154 CALVERT ST</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>11/6/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>	
24D. LOCATION <u>Baltimore Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 3 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>William H. Brown</u>		25D. ADDRESS <u>2302 W. North Ave</u>			



B620

71 10132

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10132

1. NAME OF DECEASED (Type or Print) Lonnie Burch		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 11 1 71 3:20 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 1 71 3:20 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 8/14/43		10. AGE (in years lost birthday) 24	
11. BIRTHPLACE (State or foreign country) Charleston, S.C.		12. CITIZEN OF WHAT COUNTRY? United States	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 214-14-993	
18. INFORMANT Clara L. Burch		ADDRESS 3160 Ravenwood Avenue	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E9601A		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Sidewalk	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 400 block Worsley Avenue		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 11 1 71 3:20 P. M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11 8 71	
24C. NAME OF CEMETERY or CREMATORY National Cemetery		24D. LOCATION (City, town, or county) (State) Hutchinson Pennsylvania	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Walter L. McCombs		ADDRESS 2302 W. North Ave. Balt 16	

SE101

SE101

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) THADDEUS V. JACKSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year October 27, 1971		Hour 11:25 P.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year October 27, 1971		Hour 11:25 P.
6. SEX Male		7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Nov. 17, 1943		10. AGE (In years last birthday) 27	11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF USA		13. FATHER'S NAME Thurlo Jackson		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		15. MOTHER'S MAIDEN NAME Hilda Hopkins		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		17. SOCIAL SECURITY NO. 214-38-3036		18. INFORMANT Mrs. Hilda Jackson
19. CAUSE OF DEATH 304.71		ADDRESS 3602 Callaway Avenue		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intravenous narcotism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C)				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type)		M.D. Charles S. Springate, M.D.		DATE SIGNED October 28, 1971
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-1-71		24C. NAME OF CEMETERY or CREMATORY Maryland National Mem. Park
24D. LOCATION (City, town, or county) (State) Laurel, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971		
25B. NAME OF REGISTRAR Robert E. Taber, M.D.		25C. FUNERAL DIRECTOR Arlington S. Phillips		
25D. ADDRESS 1727 N. Monroe				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 10134	
BIRTH NO. 71 10134					
1. NAME OF DECEASED (Type or Print) Clark Hattie		2. DATE AND HOUR OF DEATH November 2, 1971 8:25 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1302			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 2600 Liberty Heights Ave. Baltimore, Md.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 03-08-11	
13. FATHER'S NAME Billy Davis		14. MOTHER'S MAIDEN NAME Mary		9. AGE (in years last birthday) 60 If Under 1 Yr. Months: Days: Hours: Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 911-18-6260		17. INFORMANT ADDRESS Mr. James Sly (Friend) 1326 N Fulton Ave	
18. 199.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PROBABLE CARCINOMATOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. SEVERE ANEMIA ASHD, CHF		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ASHD, CHF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-18 19 71 to 11-2 19 71 that (I) (we) last saw the deceased alive on 11-2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Aurora C. Tan, M.D. 23C. PHYSICIAN'S NAME (Type) AURORA C. TAN, M.D.				23B. DATE SIGNED 11-2-71 Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/6/71		24C. NAME OF CEMETERY OR CREMATORY Franklinton	
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave	
24D. LOCATION (City, town, or county) North Carolina		24E. LOCATION (State) North Carolina			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 10135	
BIRTH NO. 71 10135			
1. NAME OF DECEASED (Type or Print) CARRIE ANN MILES (Martin)		2. DATE AND HOUR OF DEATH October 25, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2716	
		C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 25 14 Edgecome Circle North	
5. SEX Female	6. RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1905
		9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Brookveal, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emma Walker		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-36-2141	
17. INFORMANT Louise Flemming, 2514 Edgecome Circle N.		ADDRESS	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 15 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the physician) attended the deceased from Sept. 19 69 to 24 Oct. 19 71 that (I) (we) last saw the deceased alive on 24 Oct. 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE Joshua R. Mitchell III M.D.		23B. DATE SIGNED 25 OCT. 71	
23C. PHYSICIAN'S NAME (Type) JOSHUA R. MITCHELL III M.D.		23D. ADDRESS 2202 GARRISON BLVD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/29/71	
24C. NAME of CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Kenneth Law		ADDRESS 4611 Park Heights Ave.	

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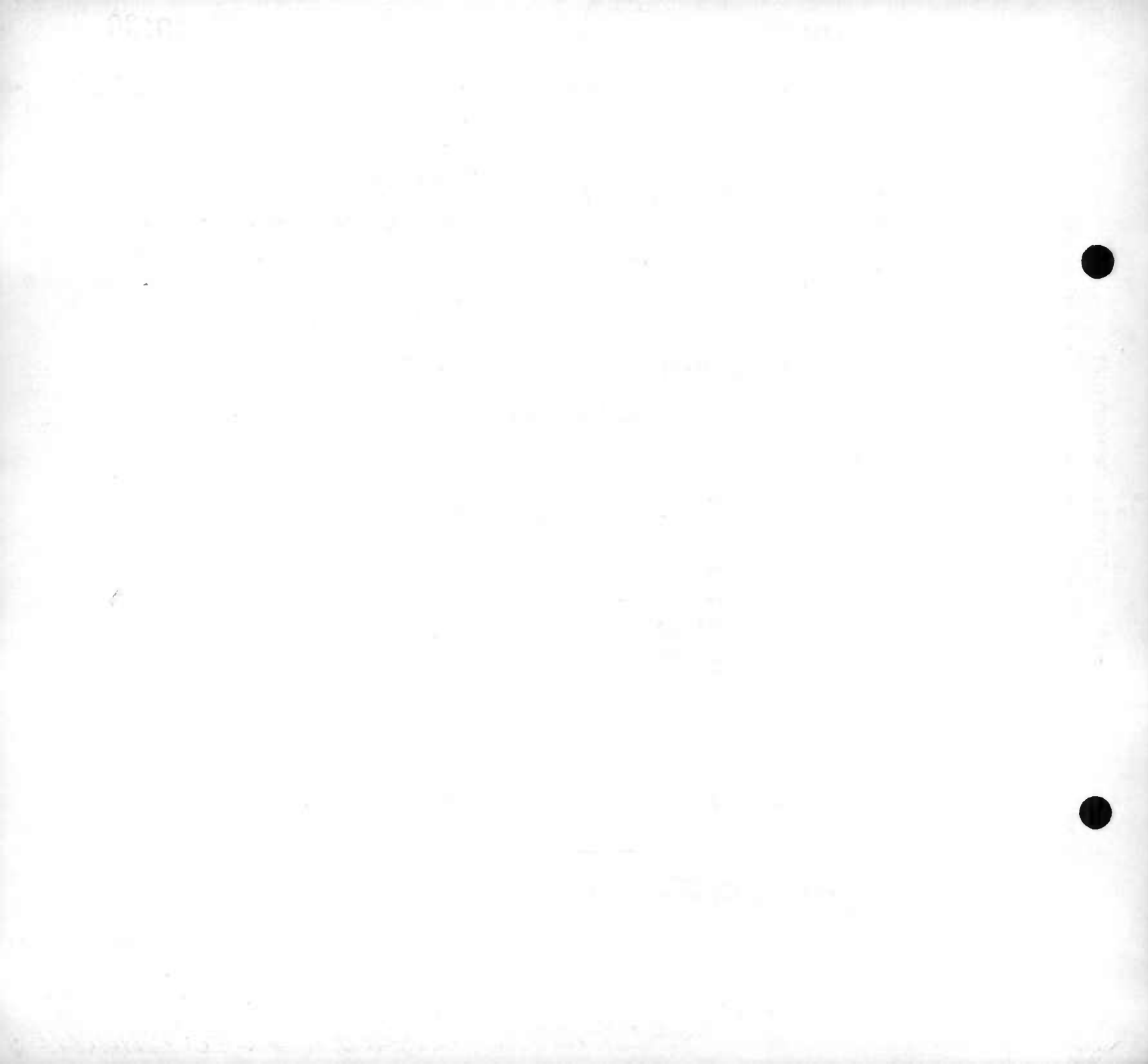
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 10136		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 10136	
1. NAME OF DECEASED (Type or Print) Fountain Charles Henry			2. DATE AND HOUR OF DEATH 11-1-71 11:25 A.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY A.A.		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Harbor View Nursing & Conv. Center			C. CITY OR TOWN Annapolis		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male 6. RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 10/18/1888		9. AGE (In years last birthday) 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Daniel Fountain			14. MOTHER'S MAIDEN NAME Eliza Blunt		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 214-54-1649		17. INFORMANT John Wells Anna Mc
18. 43791 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA Cerebral arterio sclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(B) DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V.D.		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 5/11 19 71 to 11/1 19 71 that (I) (we) last saw the deceased alive on 10/29 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Kenneth Krulvitz MD			23B. DATE SIGNED 11/1/71		23C. PHYSICIAN'S NAME (Type) Kenneth Krulvitz MD
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) Burial 11/5/71			24C. NAME OF CEMETERY or CREMATORY Franklin		24D. LOCATION (City, town, or county) (State) Deale A.A. Md.
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971			25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR William Reese & Anna Mc



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mamie Hicks		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 10	Day 29	Year 71	Hour 7:18 P.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD		Month 10	Day 29	Year 71	Hour 7:18 P.M.
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md.		B. COUNTY 802					
6. SEX female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 9-9-12		10. AGE (in years lost birthday) 59		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Brown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Anna Brown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Thomas R. Hicks		ADDRESS 2106 E. Lafayette Ave		19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
20. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes		22. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22B. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22C. TIME OF INJURY (APPROX.)		22D. HOW DID INJURY OCCUR?	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. TIME OF INJURY (APPROX.)		22G. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
23. ACTUAL SIGNATURE Peter Lipkovic, M.D.		24. NAME OF REGISTRAR Robert E. Taylor, M.D.		25. FUNERAL DIRECTOR Wm C March		26. DATE SIGNED 10/30/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-2-71		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm C March		25D. ADDRESS 928 E. North Ave.	

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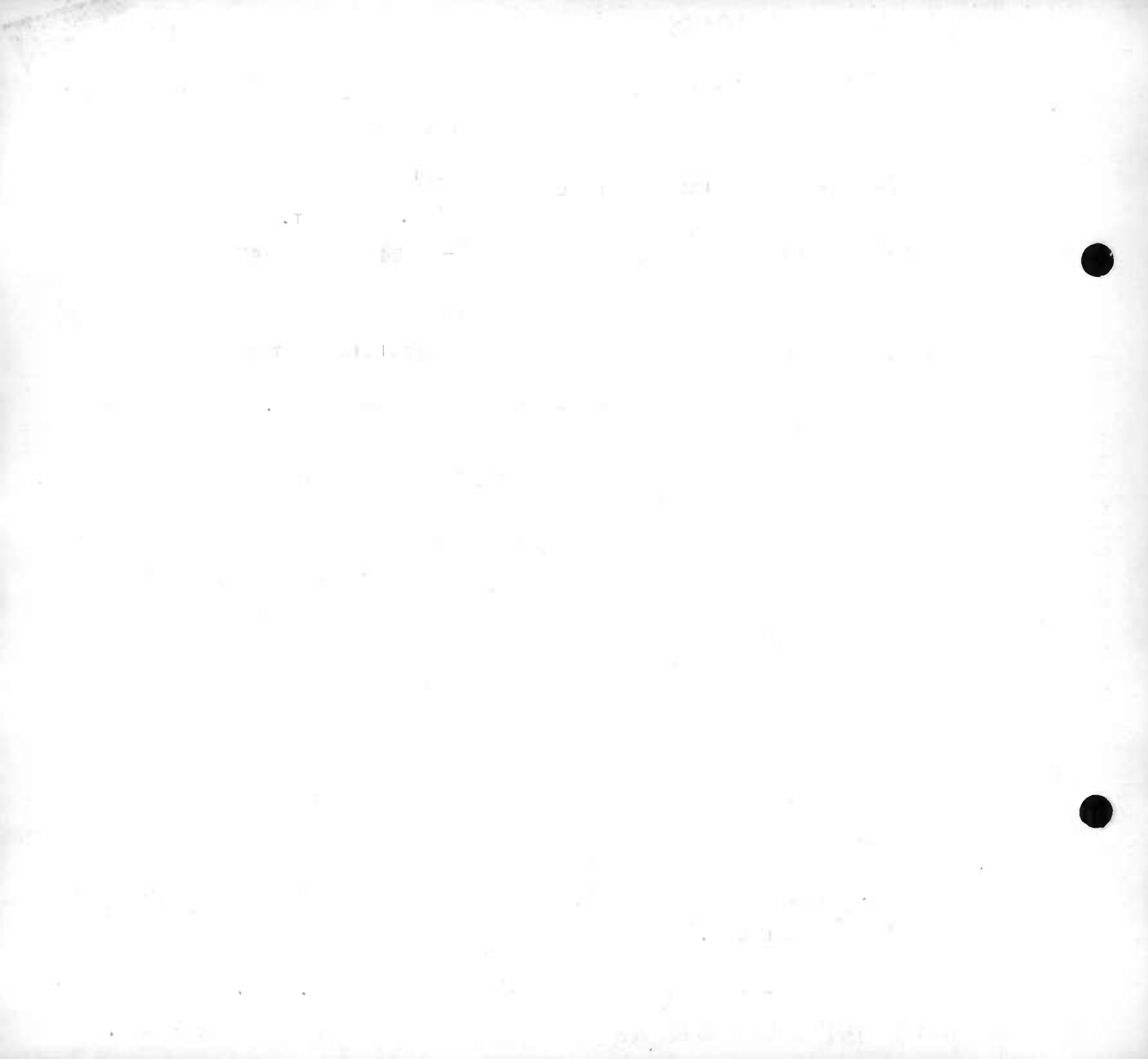
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-300 71 10138				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10138	
BIRTH NO.				S.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Naomi White</i>				2. DATE AND HOUR OF DEATH <i>10/26/71</i> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>908</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 THE JOHNS HOPKINS HOSPITAL</i>				C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <i>715 E. 22ND ST.</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-25 24</i>	9. AGE (In years last birthday) <i>47</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] <i>Clerk</i>			11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Robert Morton</i>			14. MOTHER'S MAIDEN NAME <i>PHYLICIA MORTON</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>218-22-6685</i>		17. INFORMANT ADDRESS <i>Ann White 715 E. 22nd Street</i>		
18. <i>174 X I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i>	
				(B) <i>Myxemia</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>4 mo</i>	
				(C) <i>Carcinoma of the breast spread to the lungs</i>		<i>7 yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>10/26</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>10/20</i> 19 <i>71</i> to <i>10/26</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>10/26</i> 19 <i>71</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Daniel L. Roper</i>				23B. DATE SIGNED <i>10/26/71</i>			
23C. PHYSICIAN'S NAME (Type) <i>DANIEL L. ROPER</i>				23D. ADDRESS <i>Johns Hopkins Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>11-2-71</i>		24C. NAME of CEMETERY or CREMATORY <i>Baltimore Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Balto., Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 3 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, R.D.</i>		25C. FUNERAL DIRECTOR <i>Wm C March</i>		ADDRESS <i>928 E North Ave.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <u>71 10139</u>	
7-634 71 10139 BIRTH NO. 1. NAME OF DECEASED (Type or Print) TRITEL, EDWIN JERMAH				2. DATE AND HOUR OF DEATH 11/2/71 2:30 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 904 5. CITY OR TOWN Baltimore 6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7. STREET AND NUMBER 610 E. 29th Street	
5. SEX Male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/2/91 9. AGE (In years last birthday) 80 If Under 1 Yr. Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Tritel 14. MOTHER'S MAIDEN NAME Mary Brooks				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 16. SOCIAL SECURITY NO. 213-07-05-68 17. INFORMANT VA Hospital Records ADDRESS 3900 Loch Raven Boulevard Balto., Md 21218	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIC ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. AS CVD II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 11/2/71 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21F. HOW DID INJURY OCCUR?	
22. I certify that IV (this hospital) attended the deceased from October 30th 1971 to November 2nd 19 71 , that IV (we) last saw the deceased alive on November 2nd 19 71 and that in IV (our) opinion death occurred on the date and hour and from the causes stated above. IV (We) (did) did not view the body after death.					
23A. SIGNATURE Richard W. Mellinger, MD 23C. PHYSICIAN'S NAME (Type) Richard W. Mellinger, MD				23B. DATE SIGNED 11/2/71 23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-6-71 24C. NAME OF CEMETERY or CREMATORY Lake View Memorial Park		24D. LOCATION (City, town, or county) Carroll Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Jenkins, MD		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co 4905 York Road Balto., Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10140</u>
BIRTH NO. <u>P-412</u>		71 10140		
1. NAME OF DECEASED (Type or Print) <u>Dr. Winthrop M. Phelps</u>		2. DATE AND HOUR OF DEATH <u>10-31-71</u> <u>11:15 A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00</u> <u>3038 St. Paul St.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1202</u>		
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>4-11-94</u>		9. AGE (in years last birthday) <u>77</u>		10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Arthur S. Phelps</u>		
14. MOTHER'S MAIDEN NAME <u>Gertrude I. Tappan</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>VV I</u>		
16. SOCIAL SECURITY NO. <u>WW I</u>		17. INFORMANT <u>Naomi F. Phelps</u> ADDRESS <u>Same</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Acute myocardial infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>coronary artery disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden death</u> <u>2 yrs</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 21</u> 19 <u>71</u> to <u>10/31</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Oct 22</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>William F. Renner</u>		23B. DATE SIGNED <u>11/2/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. William F. Renner</u>
23D. ADDRESS <u>3222 St. Paul St.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>11-3-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>		24D. LOCATION (City, town, or county) <u>Pikesville</u> (State) <u>Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 3 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212</u>

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10141</u>
BIRTH NO. <u>M-532</u>		71 10141		
1. NAME OF DECEASED (Type or Print) <u>Jesse Montgomery</u>		2. DATE AND HOUR OF DEATH <u>10-30-71</u> <u>1:05</u> AM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1203</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>USPHS HOSPITAL</u> <u>BALTO. MD.</u>		C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u>		6. RACE <u>B</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HWF.</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>NOV 6-1925</u> <u>45</u>
13. FATHER'S NAME <u>LANDERS CANTY</u>		14. MOTHER'S MAIDEN NAME <u>CLARA JOHNSON</u>		9. AGE (in years last birthday) <u>45</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <u>FLA</u>
17. INFORMANT <u>USPHS HOSP RECORDS</u>		ADDRESS <u>BALTO MD.</u>		
18. <u>4319 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>severe pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Coma</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>intracerebral hemorrhage</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>10 days</u> <u>10 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) lost saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Robert Kirschner</u>		23B. DATE SIGNED <u>10-30-71</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>ROBERT KIRSCHNER</u>		23D. ADDRESS <u>USPHS HOSPITAL BALTO MD.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Shipped</u>		24B. DATE <u>11-1-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Atlanta Georgia</u>
24D. LOCATION (City, town, or county) (State) <u>Atlanta Georgia</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 3 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD.</u>		25C. FUNERAL DIRECTOR <u>Rayner Sanders</u>		
25D. ADDRESS <u>2176 Preston St</u>				

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FUNERAL DIRECTOR: IMPORTANT

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S-530 71 10142				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10142	
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED (Type or Print) Newton Matilda Smith </div> <div> 2. DATE AND HOUR OF DEATH 10-31-71 71 30P M. </div> </div>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 33 THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 702			
5. SEX F				6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10B. KIND OF BUSINESS OR INDUSTRY Domestic		8. DATE OF BIRTH 11-9-06	
13. FATHER'S NAME John Henry				14. MOTHER'S MAIDEN NAME Julia Hunt		9. AGE (In years lost birthday) 64 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 213-16-5830		17. INFORMANT John T. Smith	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 410.01 CAUSE OF DEATH (A) IMMEDIATE CAUSE CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF: (B) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 24hr.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 19 to 1971, that (I) (we) lost saw the deceased alive on 10/25 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Albert L. Laforest MD				23B. DATE SIGNED 11/1/71		23C. PHYSICIAN'S NAME (Type) ALBERT L. LAFOREST MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 11-4-71		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Pk.	
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971				25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR Marshall W. Jones, Jr.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				24E. ADDRESS Harford Avenue			

H-325 71 10143

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 10143
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JULIA HUTCHINSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 31 1971 2:43 P.M.	
6. SEX female		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 3-5-06		10. AGE (In years lost birthday) 65	
11. BIRTHPLACE (State or foreign country) Greenwood, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 219-28-6419	
18. INFORMANT Mrs. Sarah Stokes		ADDRESS 2438 N. Howard St. 21218	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) no	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Russell S. Fisher</i> M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. DATE SIGNED 11-1-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-71	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213		Marshall W. Jones, Jr.	

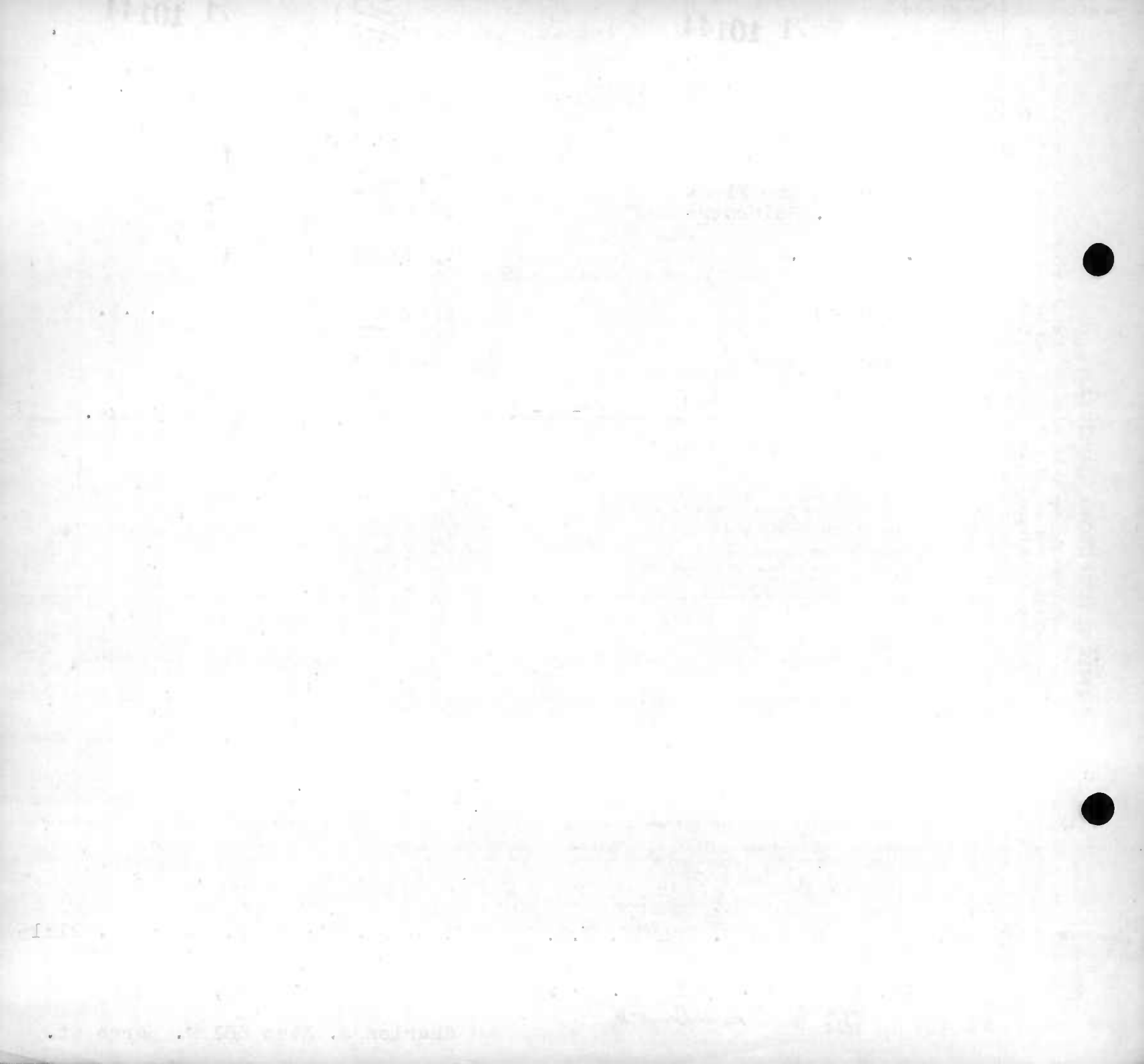
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

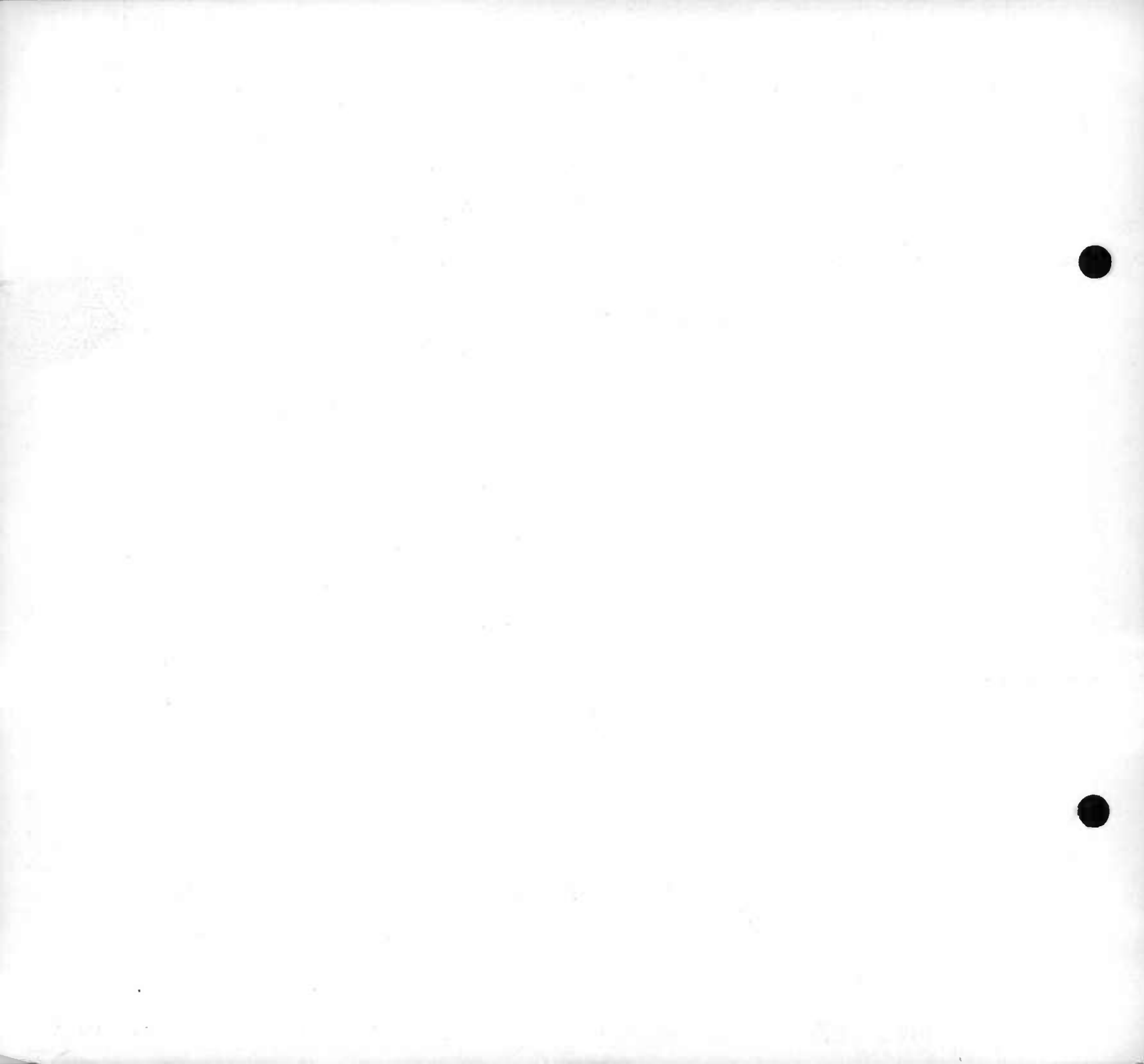
P-600 71 10144		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 10144 REG. NO.
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Gussie Perry		Dec 27, 1971 4:05 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 House in the Pines 2525 W. Belvedere Ave		A. STATE Maryland		
		B. COUNTY		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 3445 Cottage Ave		
5. SEX F.	6. RACE C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/ 84	9. AGE (In years lost birthday) 86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Andrew Henry		14. MOTHER'S MAIDEN NAME Mary Scott		12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-5314		17. INFORMANT Gloria Watts 2620 Oswego Ave.
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos 6 mo 10 y.		
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Jan 14 19 69 to Dec 27 19 71, that (I) (we) last saw the deceased alive on Dec 20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Lester N. Kolman M.D.		23B. DATE SIGNED 10/28/71		23C. PHYSICIAN'S NAME (Type) LESTER N. KOLMAN, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/29/71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn
24D. LOCATION Baltimore, Maryland		24E. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St.		



FUNERAL DIRECTOR: IMPORTANT

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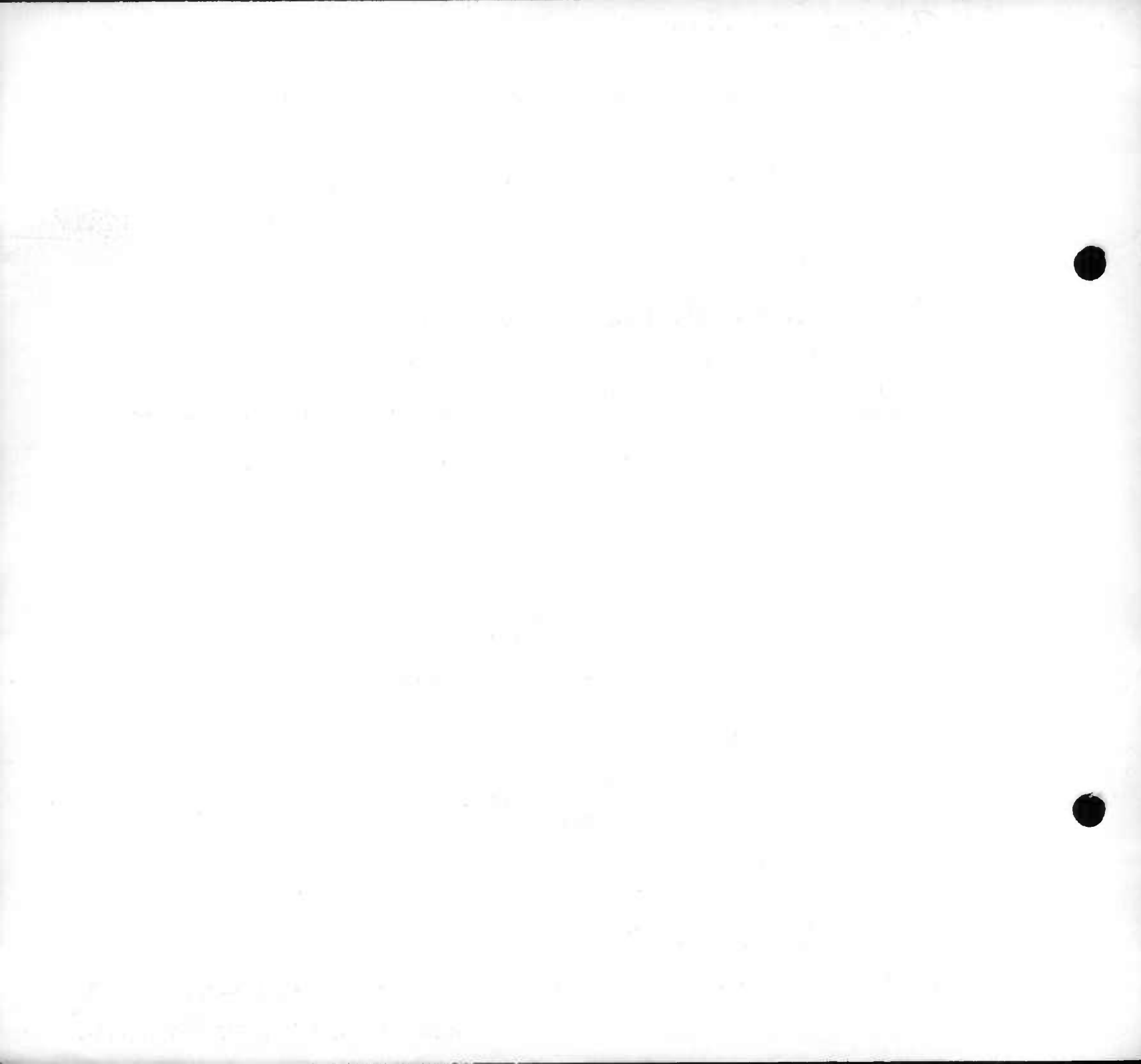
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 10145	
BIRTH NO. 71 10145		1. NAME OF DECEASED (Type or Print) Helen E. Miller		2. DATE AND HOUR OF DEATH 10/30/71 11:55 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hosp 43		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY AA 5200	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 401 Seward Ave			
5. SEX F	6. RACE Cave	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/05	9. AGE (In years last birthday) 66	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		
11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME James Drexler			14. MOTHER'S MAIDEN NAME Albina Bauer				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. A12054096B		17. INFORMANT Hosp. chart		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Renal shutdown			12 hrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: Kimbels Kidney			3 yrs	
			(C) Diabetes Mellitus			5 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			ASCRD				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/23 1971 to 10/30 1971 that (I) (we) last saw the deceased alive on 10/30 1971 and that (n) (my) (our) opinion on death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED 10/30/71		23C. PHYSICIAN'S NAME (Type) Stanford J Huber MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 11/4/71		24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	
24D. LOCATION (City, town, or county) (State) Rithie Hwy Balto Md. 21225				25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971		25B. NAME OF REGISTRAR Robert E. Fisher, MD.	
25C. FUNERAL DIRECTOR McCully Funeral Home 237 Patapsco Ave 21225				25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-230 71 10146		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 10146	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Louise Cykieta</i>		2. DATE AND HOUR OF DEATH <i>10/31/71 10.55 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>AA</i>		5. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i> <i>43</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>12-20-07</i>		9. AGE (In years last birthday) <i>63 years</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired-Biller</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Herman Denker</i>	
14. MOTHER'S MAIDEN NAME <i>Christtine</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Joseph Cykieta</i>		ADDRESS <i>8041 Highpoint Road 21226</i>		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Unnary Bladder CA</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Pneumonia</i>		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10/30</i> 19 <i>71</i> to <i>10/31</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>10/31</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Hidalgo</i>		23B. DATE SIGNED <i>10/31/71</i>		23C. PHYSICIAN'S NAME (Type) <i>Cesar Hidalgo MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/3/71</i>		24C. NAME AT CEMETERY OR CREMATORY <i>St Johns Lutheran Church Cem Hartford Co., Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 3 1971</i>		25B. NAME OF REGISTRAR <i>Robt E. J. ...</i>		25C. FUNERAL DIRECTOR <i>McDuffy Funeral Home</i>	
				ADDRESS <i>237 Patapsco Ave 21225</i>	



CERTIFICATE OF DEATH

REG. NO.

71 10147

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)K.
Julia Smith

2. DATE AND HOUR OF DEATH

12:20 AM 10/30/71

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Md. 212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

2060 Larkhall Road 21222

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

1-26-1919

9. AGE (In years
lost birthday)

52

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Tennessee

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

Wesley Rector

14. MOTHER'S MAIDEN NAME

Polly ?

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

414-07-6158

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. 01119 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

T.B. Smoking

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5-10 MIN

20 years

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/28 1971 to 10/30 1971
that (I) (we) lost saw the deceased alive on 10/30 1971 and that (I) (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

Michael Finn

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

10/30/71

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue, Baltimore, Md. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-2-71

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 3 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

John J. Duda, 7922 Wise Ave. Dundalk, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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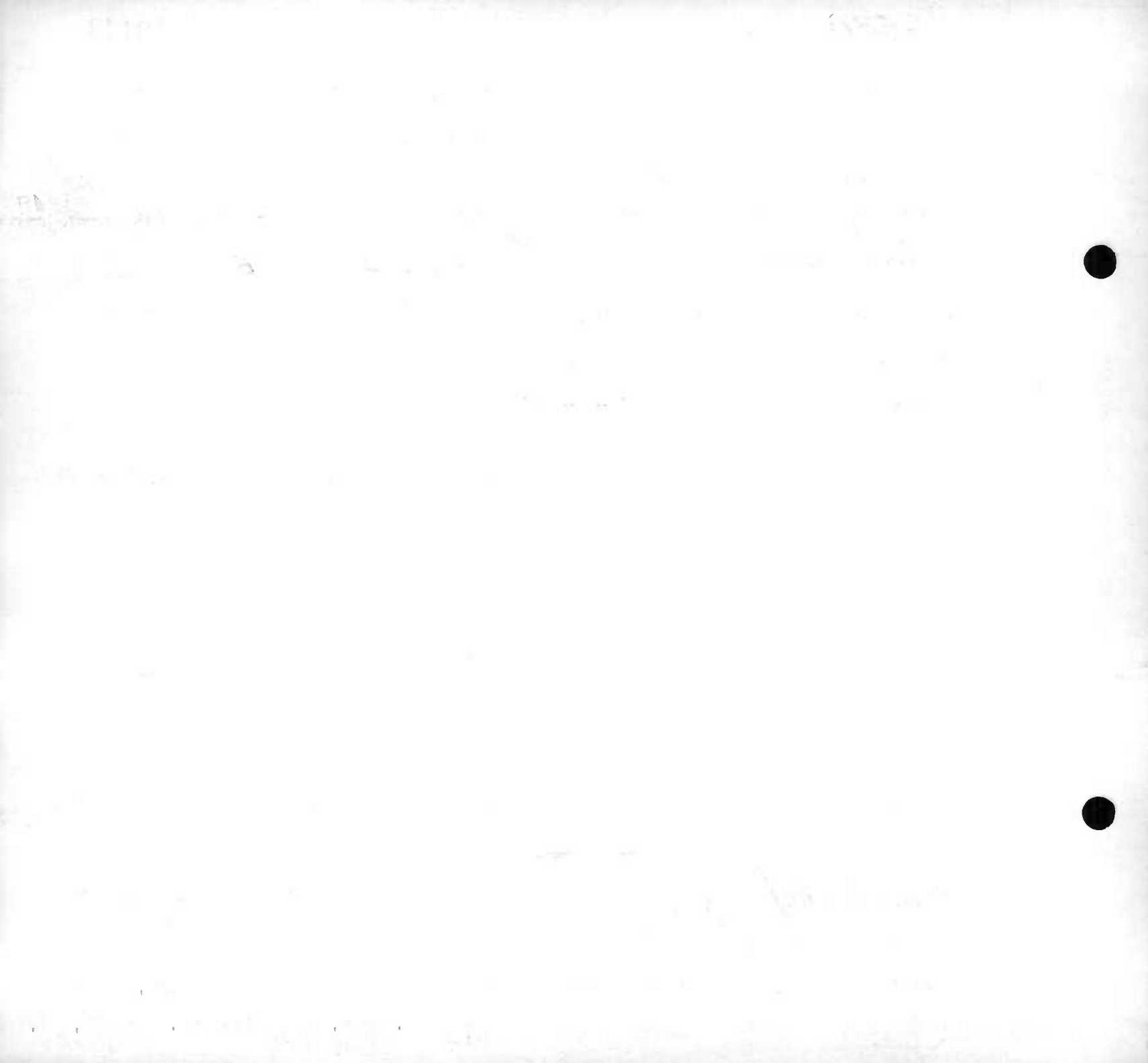
10113

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10113

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

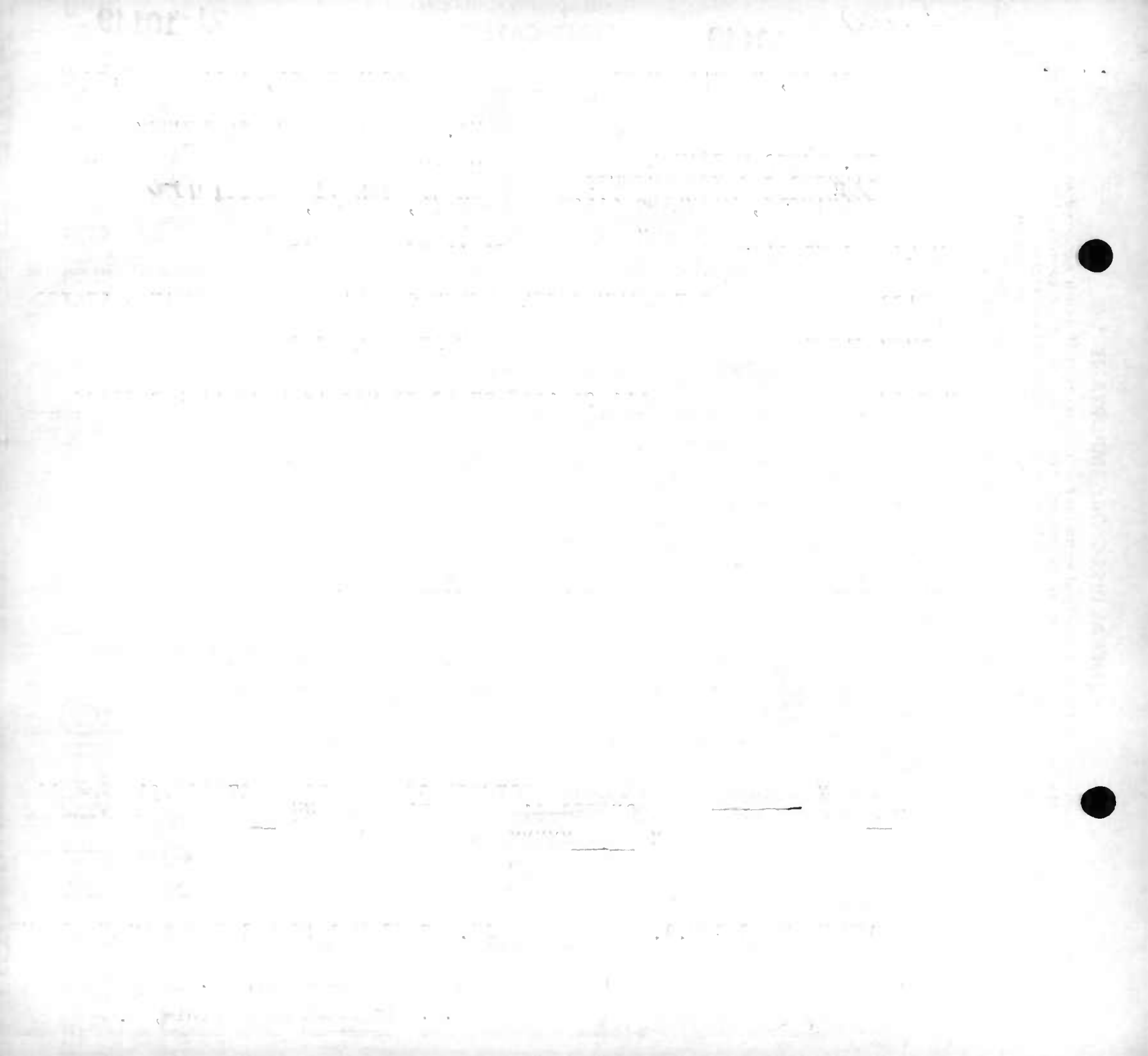
B-530 71 10148				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 10148		
BIRTH NO.				1. NAME OF DECEASED (Type or Print) DANIEL R. BENNETT JR.		2. DATE AND HOUR OF DEATH 10-31-71 4:15 M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN Edgemere		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSP. BALTIMORE, MARYLAND				E. STREET AND NUMBER 2603 LODGE FOREST RD, BALT. MD.		F. ZIP CODE 21219				
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02/02/45		9. AGE (In years, last birthday) 26	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10B. KIND OF BUSINESS OR INDUSTRY NELSON CO., SP. PT.		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME DANIEL R. BENNETT SR.				14. MOTHER'S MAIDEN NAME BESSIE LEEVY						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 214-44-7002		17. INFORMANT CHART		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE GLIOBLASTOMA (FRONTAL LOBE) 4 MO. DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MO.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION 11/3/71			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 10-19 19 71 to 10-31 19 71 that (I) (we) last saw the deceased alive on 10-31 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE Wayne L. Crowder						23B. DATE SIGNED 10-31-71				
23C. PHYSICIAN'S NAME (Type) WAYNE L. CROWDER						23D. ADDRESS Maryland Gen. Hosp.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 11/3/71			24C. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971			25B. NAME OF REGISTRAR Robert E. Barber, M.D.			25C. FUNERAL DIRECTOR John J. Duda			ADDRESS 7922 Wise Ave. Dundalk, Md. 288-4664	



FUNERAL DIRECTOR: IMPORTANT

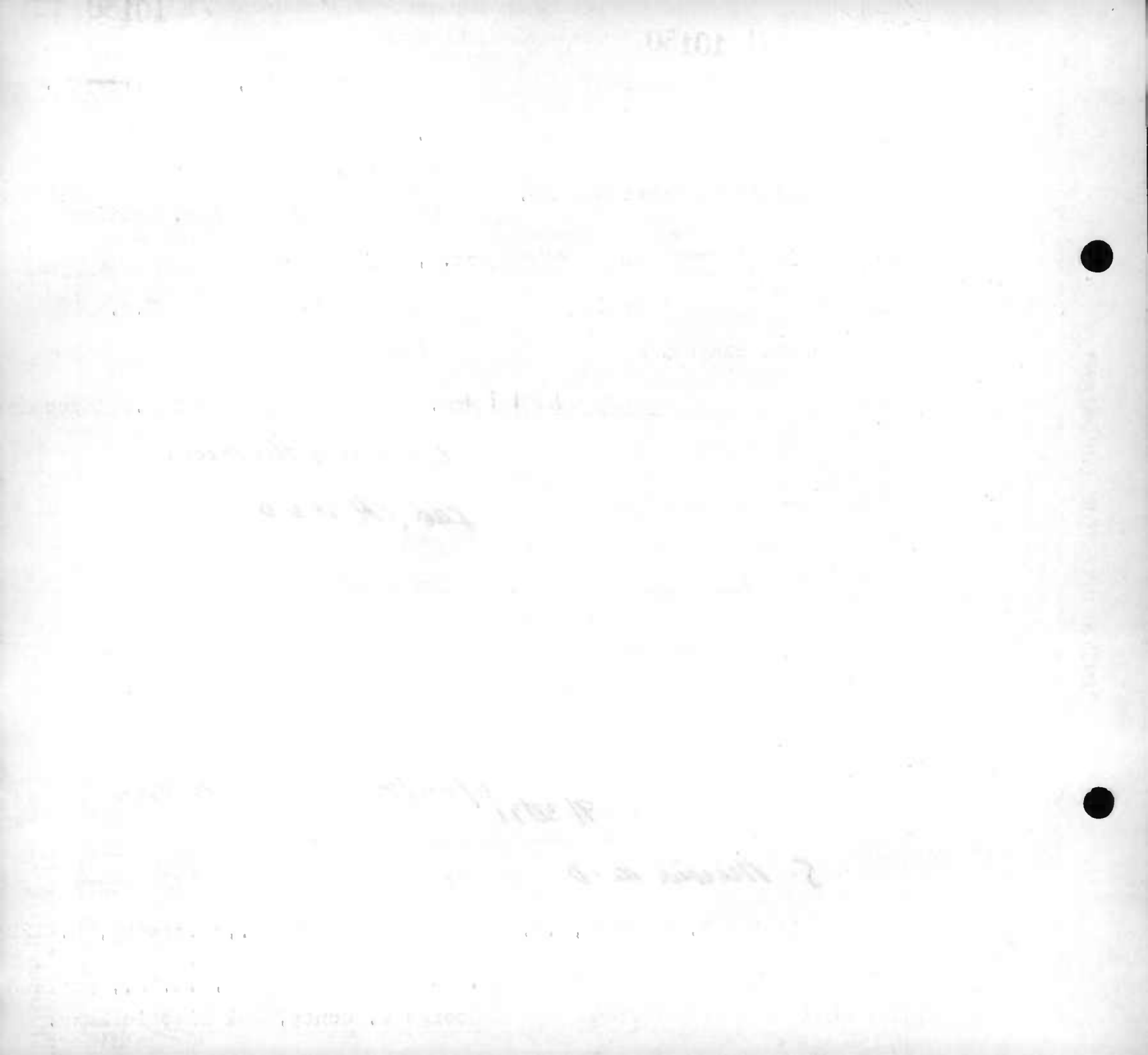
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>G-12071 10149</u>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X		REG. NO. <u>71 10149</u>	
1. NAME OF DECEASED (Type or Print) <u>GIBBS, TRAVIS ANDER</u>				2. DATE AND HOUR OF DEATH <u>OCTOBER 31, 1971</u> <u>8:55PM</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST. AGNES HOSPITAL</u> <u>WILKENS & CATON AVENUES</u> <u>BALTIMORE, MARYLAND 21229</u>				A. STATE <u>MD.</u>		B. COUNTY <u>ANNE ARUNDEL COUNTY</u> <u>5200</u>			
				C. CITY OR TOWN <u>HANOVER</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER <u>RT #2, BOX 60, DORSEY ROAD</u>					
5. SEX <u>MALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>01 13 06</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RIGGER (ret)</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>BETHLEHEM STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>RUBY GIBBS</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA FLOWERS</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO. <u>231 03 1398</u>		17. INFORMANT <u>ST AGNES HOSPITAL MEDICAL RECORDS</u>			
18. <u>162.1</u> I				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Carcinoma of the Lung with</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Wid-spread metastases.</u>					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>OCTOBER 30</u> 19 <u>71</u> to <u>OCTOBER 31</u> 19 <u>71</u> that <u>01</u> (we) last saw the deceased alive on <u>OCTOBER 31</u> 19 <u>71</u> and that <u>11:00</u> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <u>XXXXX</u> view the body after death.									
23A. SIGNATURE <u>Donato A. Vargas Jr</u>				M.D. DEGREE <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>10-31-71</u>			
23C. PHYSICIAN'S NAME (Type) <u>DONATO VARGAS M.D.</u>				23D. ADDRESS <u>ST. AGNES HOSPITAL CATON & WILKENS AVE</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/3/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 3 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Jelenko</u>		25C. FUNERAL DIRECTOR <u>R.V. Singleton/Glen Burnie, Md.</u>		ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

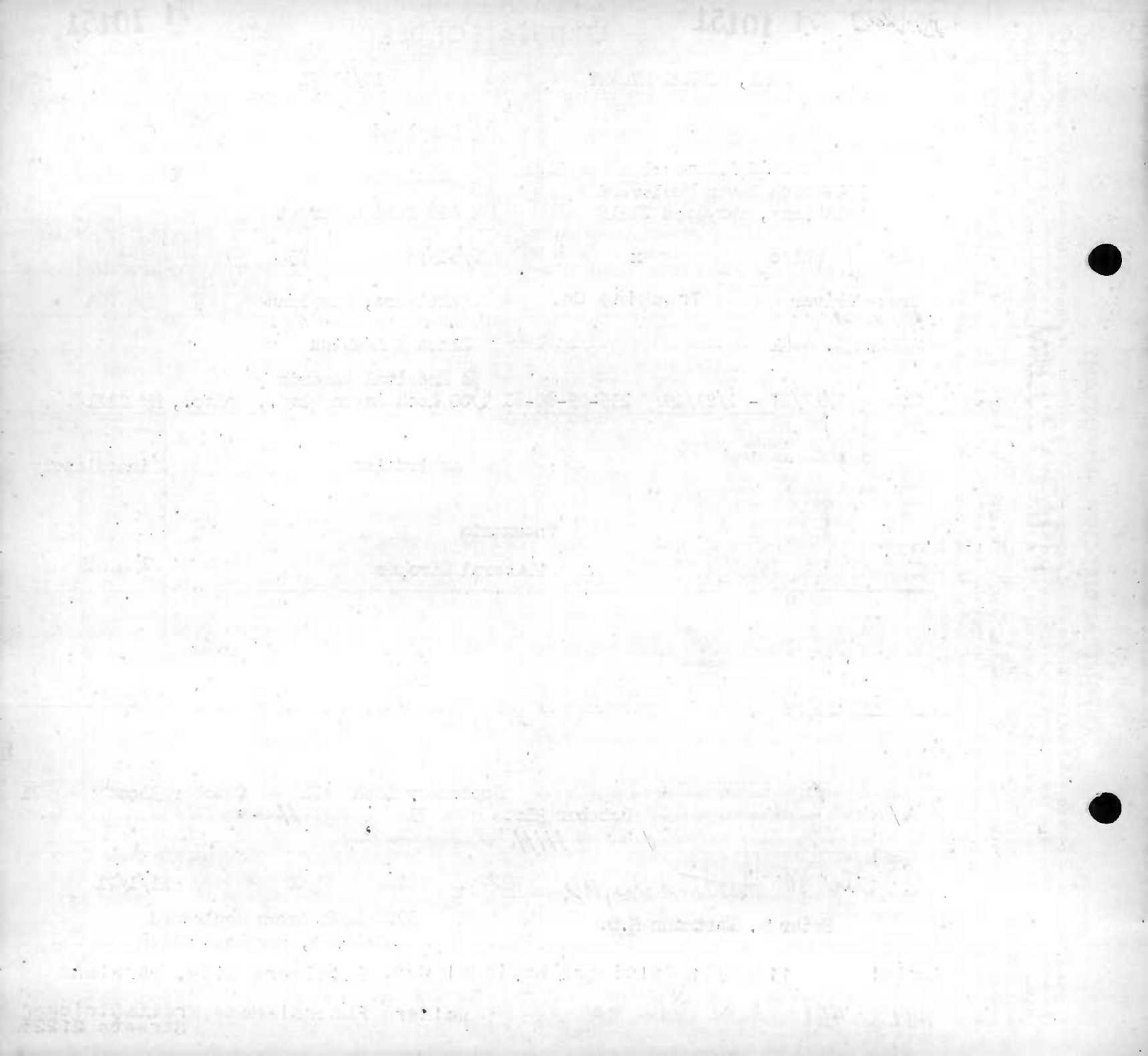
BALTIMORE CITY HEALTH DEPARTMENT				71 10150		REG. NO.	
<div style="display: flex; justify-content: space-between;"> 4-512 71 10150 </div>				<h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>			
BIRTH NO. 1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH October 29, 1971 11:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hosp.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE: Md. B. COUNTY: Baltimore C. CITY OR TOWN: Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER: 932 East Patapsco Ave. Baltimore 21225			
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 3, 1887	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10B. KIND OF BUSINESS OR INDUSTRY Trucking		9. AGE (In years last birthday) 84		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Michael Hampsey			
14. MOTHER'S MAIDEN NAME Elizabeth Cook				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 203 01 8148				17. INFORMANT Mrs. Rosella Germida 932 E. Patapsco Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) I CORONARY THROMBOSIS II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: see. A send. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19A. DATE OF OPERATION 10/29/71				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/12/71 19 to 10/29/71 19 , that (I) (we) last saw the deceased alive on 9/30/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE S. Muneses M.D.				23B. DATE SIGNED 10/30/1971		23C. PHYSICIAN'S NAME (Type) Silvino B. Muneses, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 11/2/71		24C. NAME of CEMETERY or CREMATORY Glen Haven Mem. Park	
24D. LOCATION (City, town, or county) (State) Glen Burnie, A.A. Co., Maryland				25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971			
25B. NAME OF REGISTRAR Robert E. Talley, R.D.				25C. FUNERAL DIRECTOR George J. Gonca, 4001 Ritchie Hwy. Baltimore			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400 71 10151				BALTIMORE CITY HEALTH DEPT.		REG. NO. 71 10151	
CERTIFICATE OF DEATH							
BIRTH NO.		1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
		BELL, EDWARD HYLANT			10/31/71		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				Maryland 2607			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8/31/98	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Truck driver		Trucking Co.		Baltimore, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William S. Bell				Linda M Meekins			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes 1/17/17 - 1/29/19		215-05-80-81		VA Hospital Records		3900 Loch Raven Blvd., Balto., Md 21218	
18. 4369 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE			
ANTECEDENT CAUSES				Aspiration			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.				(B) Pneumonia			
				(C) Bilateral Strokes			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				immediately			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from September 18th 1971 to October 31st 1971, that (1) (we) last saw the deceased alive on October 31st 1971 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Peter M. Hartmann, MD				11/1/71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Peter M. Hartmann M.D.				3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11/04/71		Baltimore National Cem.		Baltimore City, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 3 1971		Robert E. Fisher, M.D.		Walters Funeral Home		Pratt & Stricker Streets 21223	

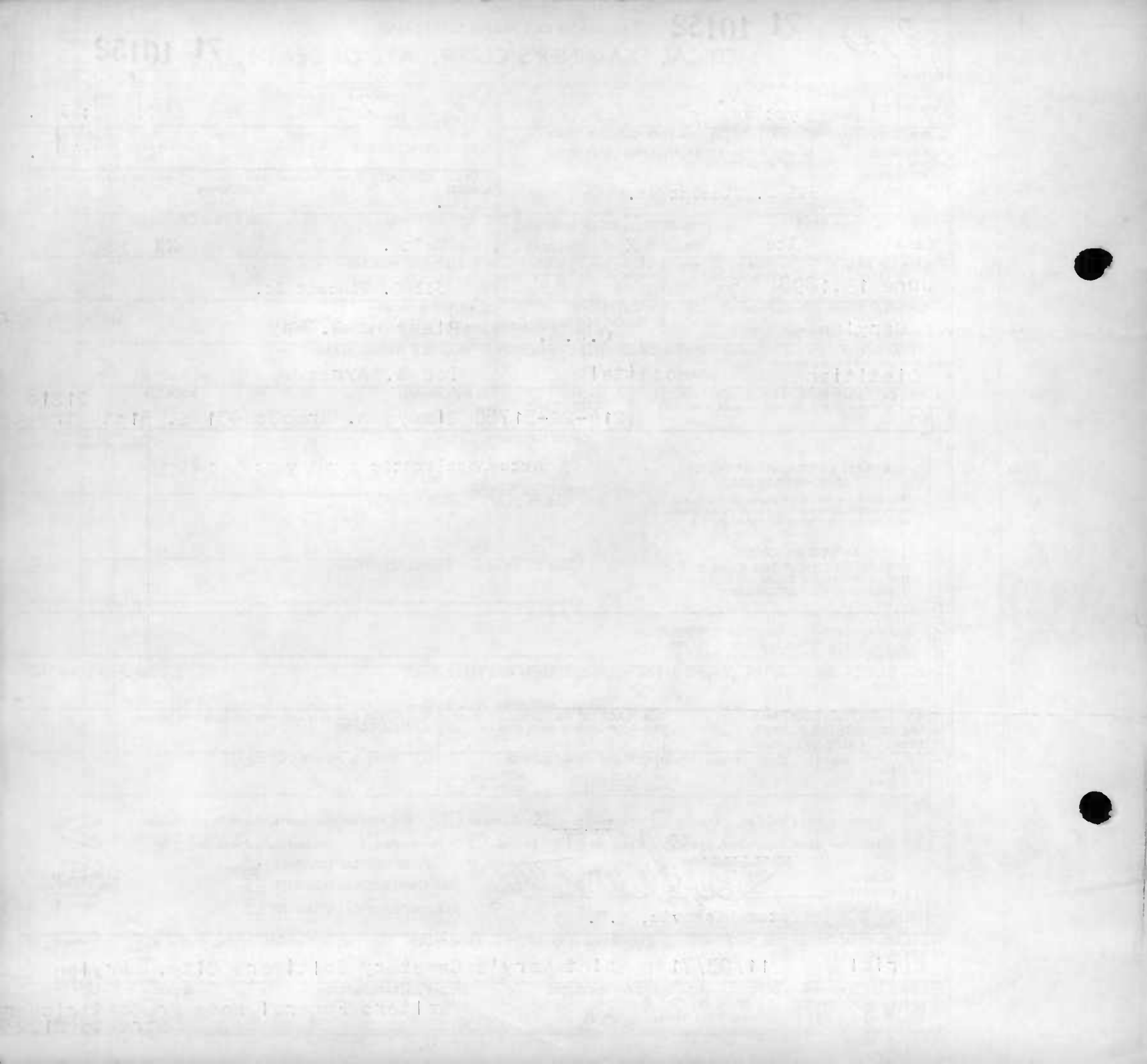


BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) V. Myrtle Ruby				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 30 Year 71 Hour 2:45 p.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 511 S. Vincent St.				3. DATE PRONOUNCED DEAD Month 10 Day 30 Year 71 Hour 2:45 p.m.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1903							
6. SEX female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH June 13, 1898		10. AGE (In years lost birthday) 73		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Pleasant S. May		14. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dietitian		14B. KIND OF BUSINESS OR INDUSTRY Hospital		15. MOTHER'S MAIDEN NAME Ida K. Ayres	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 214-22-5178		18. INFORMANT B. Gladys A. Brooks		ADDRESS 431 E. 31st Street 21218	
19. CAUSE OF DEATH 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10/31/71 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/03/71		24C. NAME of CEMETERY or CREMATORY Saint Mary's Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore City, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 3 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Walters Funeral Home Pratt & Stricker Streets 21223			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10153	
J-250 71 10153				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Cherry Jackson</u>		2. DATE AND HOUR OF DEATH <u>11/1/71</u> <u>9:05P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>CITY</u>		1702	
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND General Hosp</u>		C. CITY OR TOWN <u>CITY</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>308 Eutaw Pl</u>		21217			
5. SEX <u>F</u>	6. RACE <u>black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-20</u>	9. AGE (in years, last birthday) <u>51</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Helen Pugh</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chart</u>	
18. <u>425 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulm Embolism</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Constrictive Heart Band</u> (C) <u>Myocardopathy</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>11/1/71</u> 19 <u>71</u> to <u>11/1/71</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>11/1/71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>George C. Samaras</u>		23B. DATE SIGNED <u>11/1/71</u>		23C. PHYSICIAN'S NAME (Type) <u>GEORGE C. SAMARAS MD</u>	
23D. ADDRESS <u>MCH</u>		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>11/3/71</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Greenview</u>		24D. LOCATION (City, town, or county) <u>NC</u>		24E. STATE <u>NC</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>1234 Main St. N.C.</u>	



M-610

71 10154

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

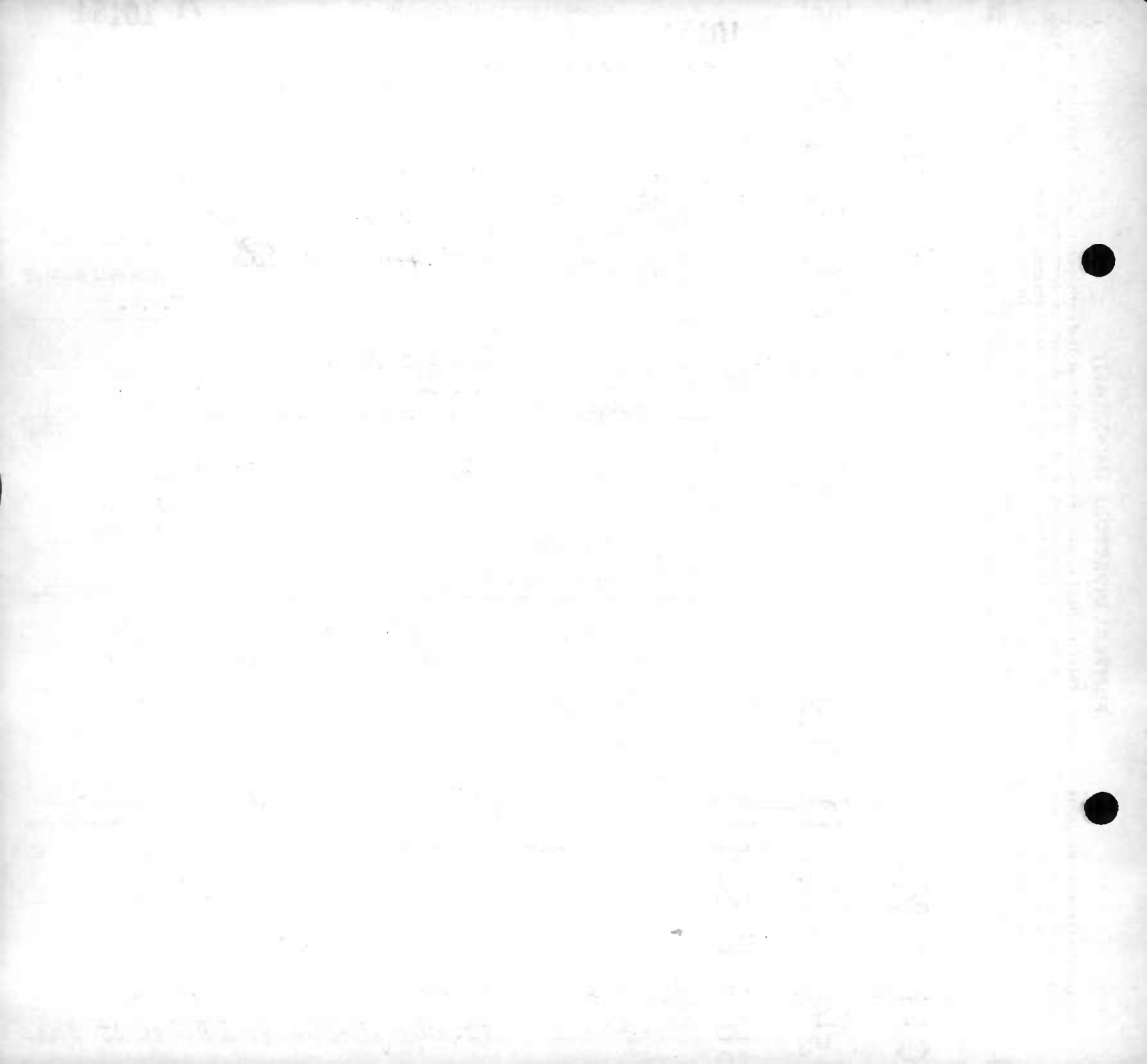
REG. NO.

71 10154

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

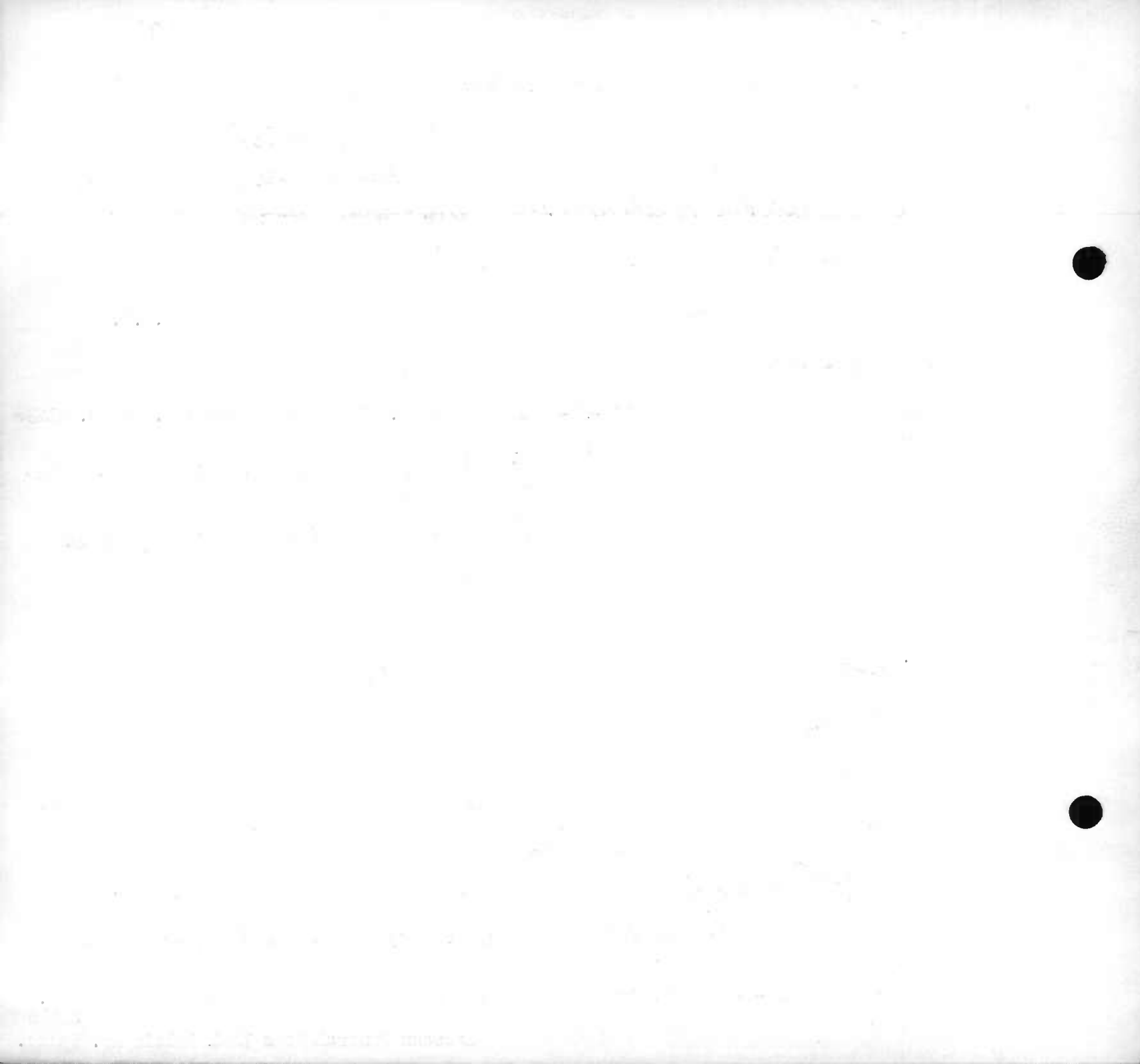
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM MURPHY		2. DATE AND HOUR OF DEATH NOV. 1, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) A. STATE Maryland B. COUNTY 1204		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS BALTIMORE, MARYLAND 21224 4940 Eastern Avenue		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2308 Barclay Street 21218	
5. SEX Male	6. RACE B Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/5/1919	9. AGE (In years last birthday) 52	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HENRY MURPHY		14. MOTHER'S MAIDEN NAME Lizzie May	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 214-18-6859		17. INFORMANT B.C.H.-RECORDS ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224	
18. CAUSE OF DEATH 412.44185X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ? PROSTATE CA, ANEMIA, PNEUMONIA		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIORESPIRATORY ARREST IMMEDIATE		(B) YEARS MONTHS	
(C) DUE TO, OR AS A CONSEQUENCE OF: CVA		(D) YEARS MONTHS		(E) YEARS MONTHS	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 9/14/71 19 to 11/1/71 19 that (I) was last saw the deceased alive on NOV 1 19 71 and that (in my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.					
23A. SIGNATURE John J. Chabalko, MD		23B. DATE SIGNED NOV. 1, 1971		23C. PHYSICIAN'S NAME (Type) JOHN J. CHABALKO, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-4-71		24C. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PARK ARBUTUS, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Randolph J. Collick 2431 E. Oliver St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

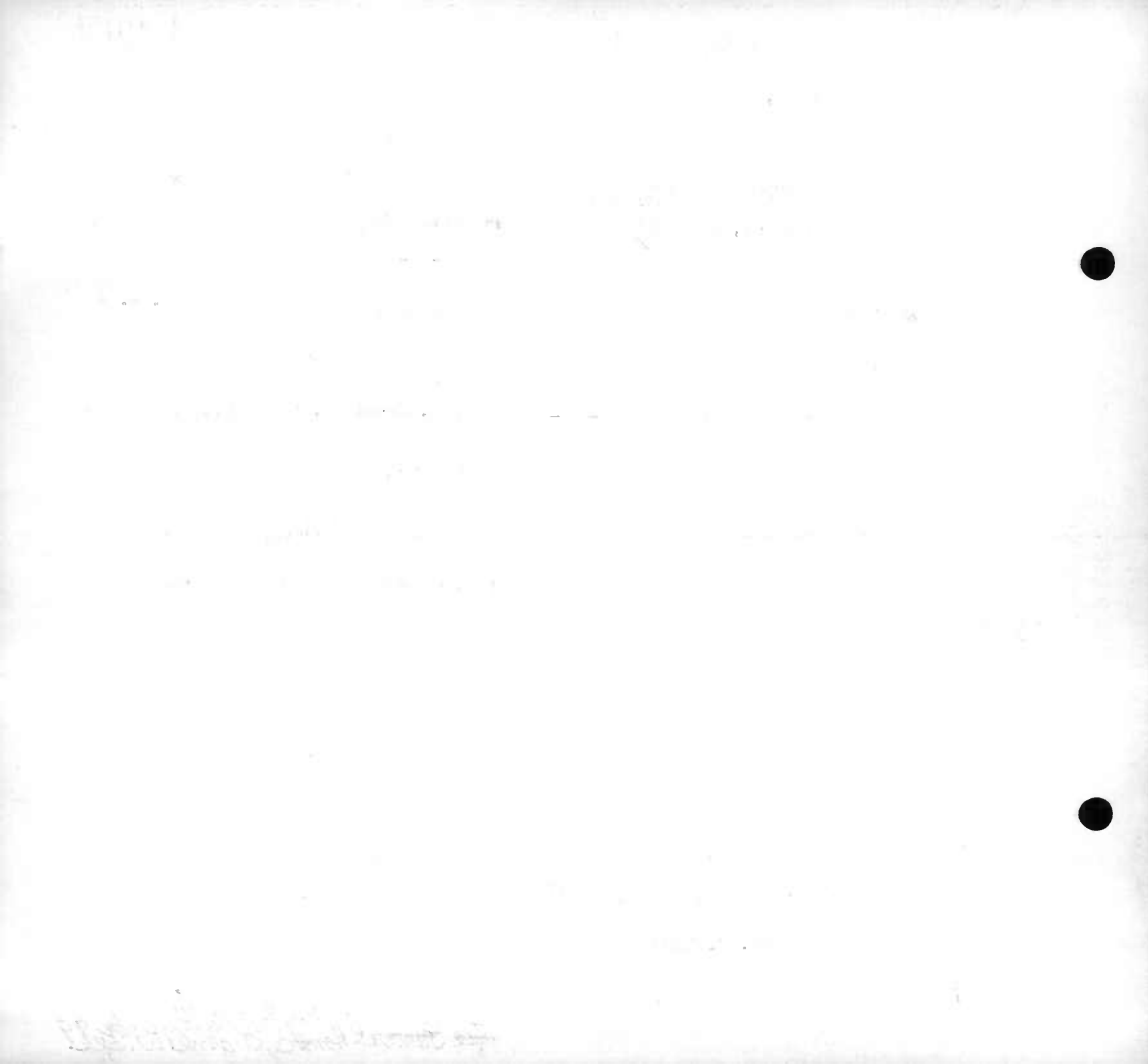
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10155</u>
1. NAME OF DECEASED (Type or Print) <u>MATILDA WINTERSTEIN</u>		2. DATE AND HOUR OF DEATH <u>11-1-71</u> <u>1030</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Gould's Convalesarium</u> <u>6116 Belair Rd. Balto. 21206 Md.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN <u>Hulltown Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>4505 Fitch Ave.</u>		
5. SEX <u>Female.</u>	6. RACE <u>White.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 Feb 1890</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Homekeeping</u>		9. AGE (In years lost birthday) <u>81</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Jacob Landenklos</u>		14. MOTHER'S MAIDEN NAME <u>Mary Rye</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-22-5706A</u>		17. INFORMANT ADDRESS <u>Mrs May E. Fitch 4501 Fitch Ave. Balto. 21236</u>
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Cerebral Vascular Accident.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Atherosclerotic Cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Decomposition</u>		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>11-1-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR? <u>None</u>				
22. I certify that (I) (this hospital) attended the deceased from <u>fall</u> 19<u>65</u> to <u>11-1</u> 19<u>71</u> that (I) <u>do</u> last saw the deceased alive on <u>11-1-71</u> 19<u>71</u> and that in (my) <u>do</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>do</u> (did) (did not) view the body after death.				
23A. SIGNATURE <u>John C. Hyle</u>		23B. DATE SIGNED <u>11-1-71</u>		23C. PHYSICIAN'S NAME (Type) <u>John C. Hyle</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-5-71</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Gardens</u>		24D. LOCATION (City, town, or county) (State) <u>Belair Harford Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fitch</u>		
25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>		ADDRESS <u>7101 Belair Rd. Balto. 21236</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10156</u>
BIRTH NO. <u>L-200 71 10156</u>		1. NAME OF DECEASED (Type or Print) <u>LAWS, WILLIAM A</u>		
2. DATE AND HOUR OF DEATH <u>10-31-71 3:15 A. M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION <u>39 PROVIDENT HOSPITAL 2600 LIBERTY HEIGHT AVE BALTIMORE, MD 21225</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1505</u>		
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>8-02-92</u>		9. AGE (In years last birthday) <u>79</u>		10. UNDER 1 Tr. Months: Days: Hours: Min.
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		
13. FATHER'S NAME <u>Taylor Laws</u>		14. MOTHER'S MAIDEN NAME <u>Betty Harris</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes World War #I</u>		16. SOCIAL SECURITY NO. <u>224-I2-I006A</u>		17. INFORMANT <u>Mrs. Jennie A. Laws (Wife)</u>
18. <u>269.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Hypoxia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pulmonary Edema</u> <u>Hypotension; Malabsorption</u> <u>Syndrome</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>October 31</u> 19 <u>71</u> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Dr. O. Loot</u>				23B. DATE SIGNED <u>10-31-71</u>
23C. PHYSICIAN'S NAME (Type) <u>DR. O. LOOT</u>		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/4/71</u>		24C. NAME OF (CEMETERY) OR CREMATORY <u>Mt. Zion Baptist Church</u>
24D. LOCATION (City, town, or county) (State) <u>Downings, Virginia</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Talley, R.D.</u>		25C. FUNERAL DIRECTOR <u>Lee Funeral Home, Eugene W. Lee</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 10157
BIRTH NO. 10157		1. NAME OF DECEASED (Type or Print) HELEN CATHERINE MEMMERT		
2. DATE AND HOUR OF DEATH NOV. 2, 1971 12:15 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD NORTH CHARLES GEN. HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2724 N. Charles St Bk 18 Md		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1/4/1895		9. AGE (In years last birthday) 76		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10B. KIND OF BUSINESS OR INDUSTRY Department Store		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY U.S.		13. FATHER'S NAME LEWIS MILLER		
14. MOTHER'S MAIDEN NAME LENA RUPP		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 220-05-4812		17. INFORMANT PATIENT		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACUTE Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mellitus				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —
22. I certify that (I) (this hospital) attended the deceased from OCT. 30, 1971 to NOV. 2, 1971 that (I) (we) last saw the deceased alive on 11/2/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE [Signature]		23B. DATE SIGNED 11/2/71		23C. PHYSICIAN'S NAME (Type) AGATON H. ESCALANTE, M.D.
23D. ADDRESS 66 NORTH CHARLES GENERAL HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5 Nov 71		24C. NAME OF CEMETERY OR CREMATORY London Park Cem
24D. LOCATION Balti Md				
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1971		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Beverly Furrer/Hume
ADDRESS Balti Md				

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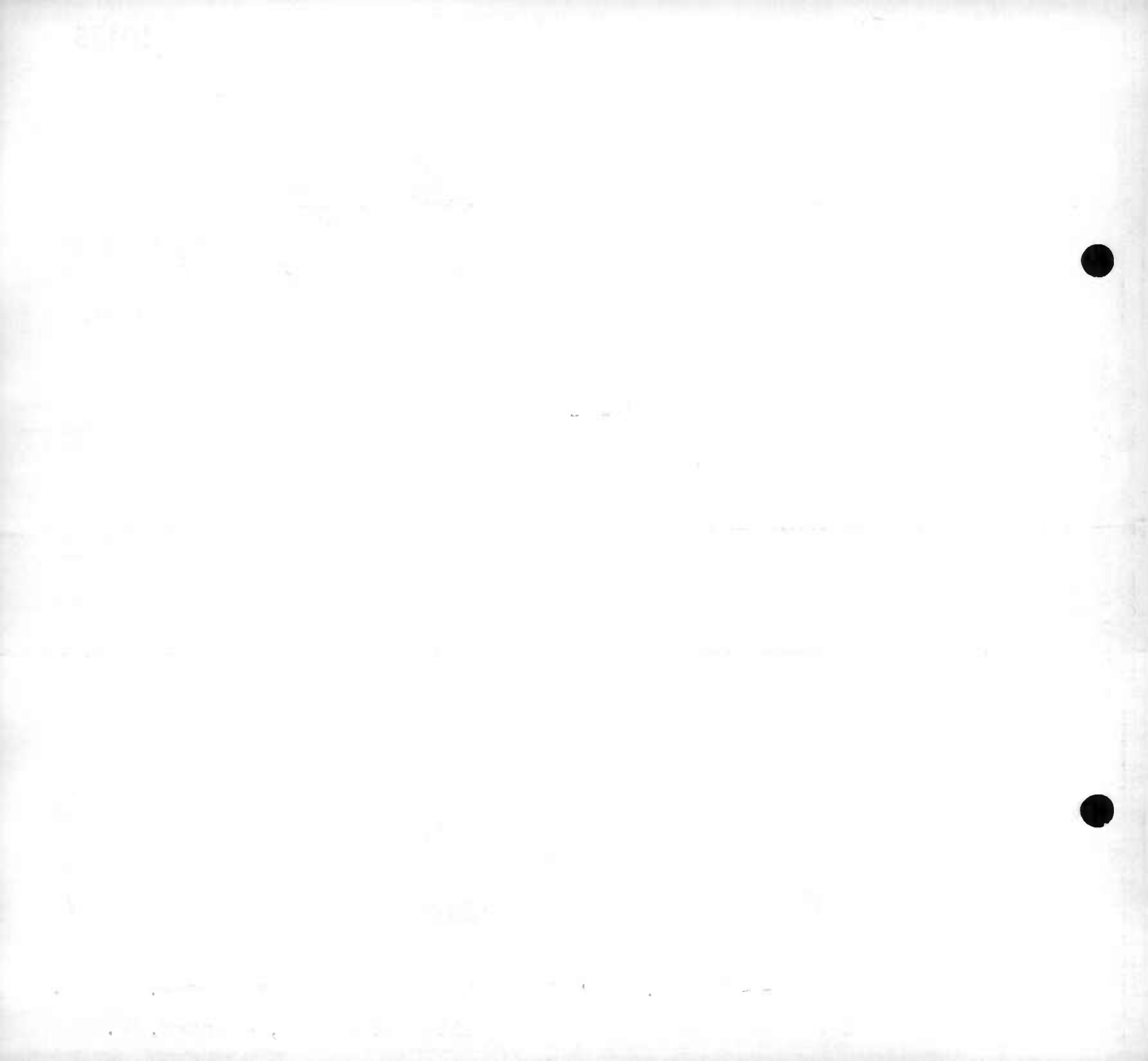
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10158	
A-652 71 10158				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CHARLES N. ARMACOST		2. DATE AND HOUR OF DEATH 10/31/71 at 2³⁰ a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Montebello State Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore B. COUNTY 5300 C. CITY OR TOWN Upperco D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Dark Hollow Rd		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/13/82	9. AGE (in years last birthday) 88
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Upperco, Md	
13. FATHER'S NAME John Armacost			14. MOTHER'S MAIDEN NAME Martha Bush		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-36-8386		17. INFORMANT ADDRESS Hospital record	
18. 4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) Acute Cardiac failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. arteriosclerotic cardiovascular disease.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. DATE OF OPERATION 0			19A. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that at (this hospital) attended the deceased from 3/9 19 64 to 10/31 19 71 that (I) (we) last saw the deceased alive on 10/31 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel A. Hanna, M.D.			23B. DATE SIGNED 10/31/1971		23C. PHYSICIAN'S NAME (Type) DANIEL A. HANNA, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-3-71		24C. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery	
24D. LOCATION (City, town, or county) (State) Upperco Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 4 1971		25B. NAME OF REGISTRAR John E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Eline Funeral Home, Hampstead, Md.		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 10159	
M-250 71 10159							
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARIE Alice McQueeney		2. DATE AND HOUR OF DEATH NOVEMBER 1, 1971 1053 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE N.J. B. COUNTY VINELAND		C. CITY OR TOWN VINELAND		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 91 Columbia Ave.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-14-42	9. AGE (In years last birthday) 29	If Under 1 Tr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO, MD		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Thomas McQueeney		14. MOTHER'S MAIDEN NAME Helen Marie Butke		17. INFORMANT ADDRESS CHART			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE					
18. 456 X I		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF:				2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Spastic baby						74 years	
19A. DATE OF OPERATION 2 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/1 19 71 to 11/1 19 71 that (I) was lost saw the deceased alive on 11/1 19 71 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE David B Posner MD				23B. DATE SIGNED 11/1/71		23C. PHYSICIAN'S NAME (Type) David B Posner MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 4, 1971		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Switzland Pa. Co Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1971		25B. NAME OF REGISTRAR Robert E. Faber, MD		25C. FUNERAL DIRECTOR Arthur H. Hester		25D. ADDRESS 257 Green St. Baltimore, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-340 71 10160		BALTIMORE CITY HEALTH DEPARTMENT		71 10160	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) BERTHA A. DUDLEY			2. DATE AND HOUR OF DEATH 3 NOV 71 8:30 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIV. OF MD. HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 907 C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1607 CARSWELL ST.		
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 1905	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY at Home	11. BIRTHPLACE (State or foreign country) Gloucester VA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME THOMAS DUDLEY			14. MOTHER'S MAIDEN NAME GOORGIANNA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Augusta Pulliam 1610 GORDON RD		
18. 431.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CEREBRAL HEMORRHAGE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HYPERTENSION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that it (this hospital) attended the deceased from 31 OCT 1971 to 3 NOV 1971 that it (we) last saw the deceased alive on 3 NOV 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Arthur M. Wagner M.D.			23B. DATE SIGNED 3 NOV 71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) ARTHUR M. WAGNER M.D.			23D. ADDRESS UNIV HOSP.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burned		24B. DATE 11/8/71		24C. NAME OF CEMETERY or CREMATORY ANT Auburn	
24D. LOCATION (City, town, or county) (State) BALTO MD					
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Marlene R. Hays (389) 1111	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10161	
H-623 71 10161				CERTIFICATE OF DEATH	
BIRTH NO. H-623		1. NAME OF DECEASED (Type or Print) <u>Doctor James E. Hairston</u>		2. DATE AND HOUR OF DEATH <u>11/1/71</u> <u>1:00 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1702</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>411 W. Lanvale St.</u>	
5. SEX <u>Male</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/16/27</u>	9. AGE (In years last birthday) <u>44</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CONTRACTOR</u>		11. BIRTHPLACE (State or foreign country) <u>Marysville Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Price Hairston</u>		14. MOTHER'S MAIDEN NAME <u>Sarah M. Minlon</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-640</u>		17. INFORMANT <u>Bunloy Hairston</u> ADDRESS <u>333 Dawson St</u>	
18. <u>571.9</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cirrhosis</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>10/31/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Pneumonia</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/22</u> 19 <u>71</u> to <u>11/1</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>11/1</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael A. Silverman MD</u>				23B. DATE SIGNED <u>11/1/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael A. Silverman MD</u>				23D. ADDRESS <u>Maryland Gen. Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/4/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Forest Hill</u>	
24D. LOCATION (City, town, or county) (State) <u>Marysville Va</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>Dr. ...</u> ADDRESS <u>135 ...</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

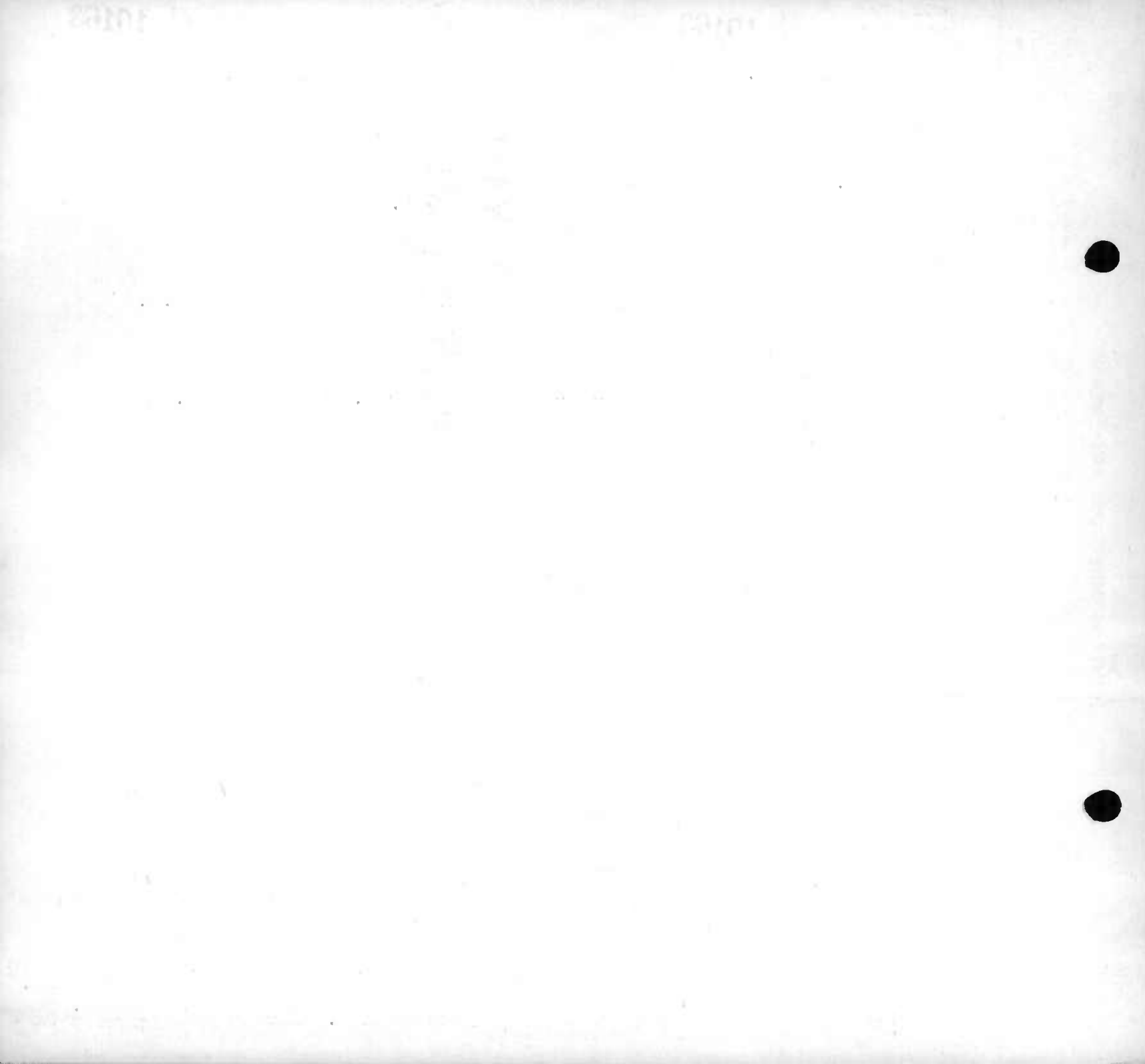
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10162</u>	
BIRTH NO. <u>B-640</u>		71 10162			
1. NAME OF DECEASED (Type or Print) <u>BLANCHE BURLEY</u>			2. DATE AND HOUR OF DEATH <u>Nov. 11, 1971</u> <u>12:55 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>BON SECOURS HOSPITAL</u> <u>2025 W FAYETTE ST</u>			A. STATE <u>MD</u> B. COUNTY <u>PASADENA</u> C. CITY OR TOWN <u>PASADENA</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <u>F</u> 6. RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>June 1, 1904</u> 9. AGE (in years last birthday) <u>67</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Calvert County, MD</u>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Julius Parker</u>			14. MOTHER'S MAIDEN NAME <u>Rachel Borne</u>		
15. War/Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>216-22-2539A</u>		
17. INFORMANT <u>VONDEL BURLEY</u>			ADDRESS <u>Pasadena P.D.</u>		
18. <u>436-91</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>coronary-vascular accident</u>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>arteriosclerotic heart disease</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>10-25-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10-25-71</u> to <u>11-1-71</u> and that (I) (we) last saw the deceased alive on <u>11-1-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Cumley</u>			23B. DATE SIGNED <u>11-1-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>GERARDO M LOPEZ</u>			23D. ADDRESS <u>BON SECOURS Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/1/71</u>		24C. NAME of CEMETERY or CREMATORY <u>MAGDOENY - MD</u>	
24D. LOCATION (City, town, or county) <u>MAGDOENY - MD</u>		24E. NAME of REGISTRAR <u>Robert E. Fisher, M.D.</u>		24F. FUNERAL DIRECTOR <u>Marjorie A. Hughes</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Marjorie A. Hughes</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

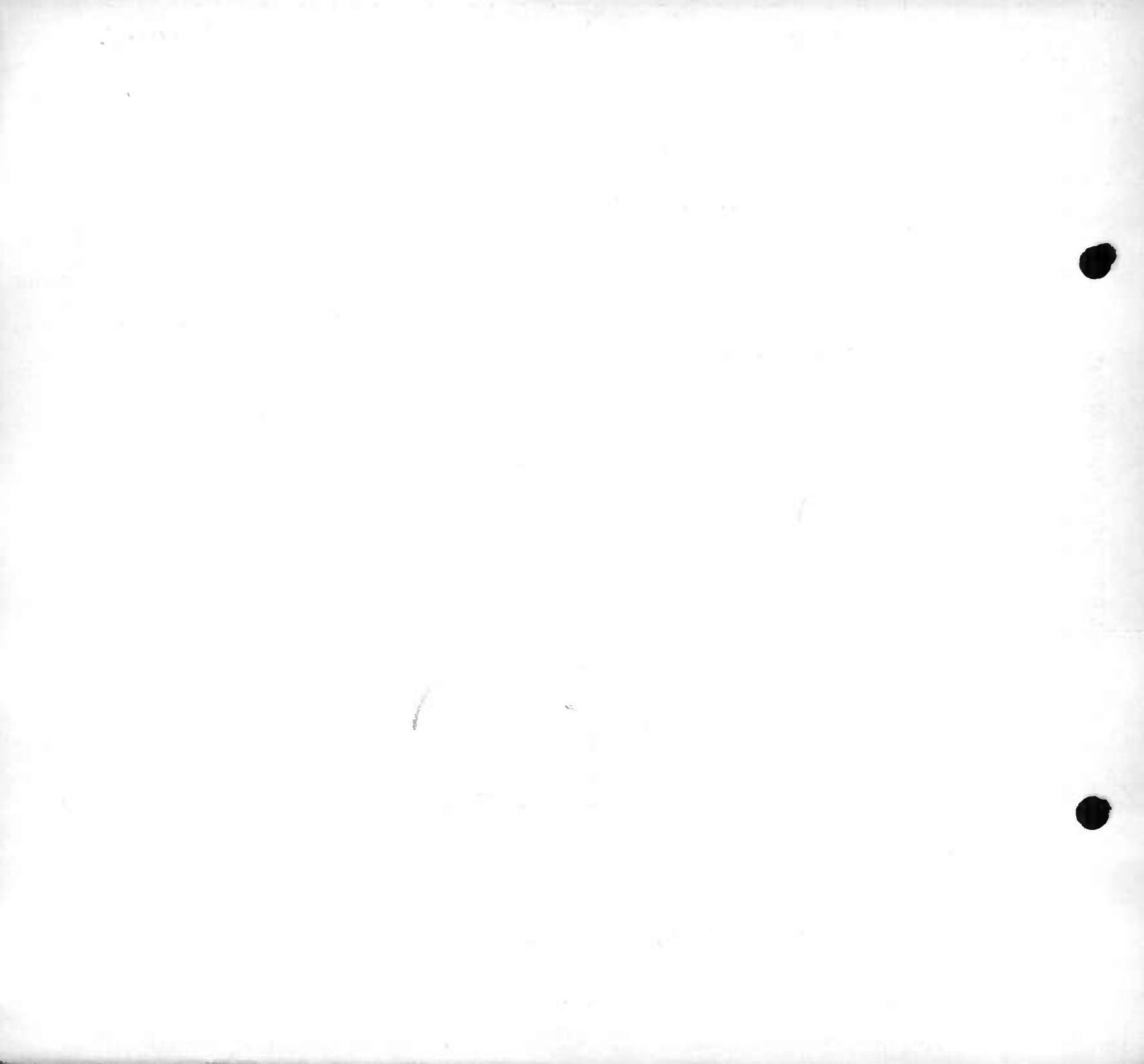
BIRTH NO. 71 10163				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 71 10163	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Frances E. Senft				2. DATE AND HOUR OF DEATH November 2nd, 1971 8³⁰ 4 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3000 E. Monument Street				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 701			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 3000 E. Monument Street			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/31/12	9. AGE (In years lost birth day) 59	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Tailoring		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME George Zhinskey				14. MOTHER'S MAIDEN NAME Frances Zelner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. 215-07-5156		17. INFORMANT ADDRESS Charles T. Senft 3000 E. Monument St			
18. 13401 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma - Colon + rectum ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 2 Metastases				INTERVAL BETWEEN ONSET AND DEATH 6 mo.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/1/71 to 11/2/71 19 71 that (I) (we) last saw the deceased alive on 11/1/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph S. Blum MD M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/3/71	
23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD		23D. ADDRESS 1111 N. CALVERT ST					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/5/71		24C. NAME of CEMETERY or CREMATORY Gardensof Faith		24D. LOCATION (City, town, or county) (State) Radecke off Kenwood Ave, Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Frederick D. Miller, Inc 3019 E. Monument St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

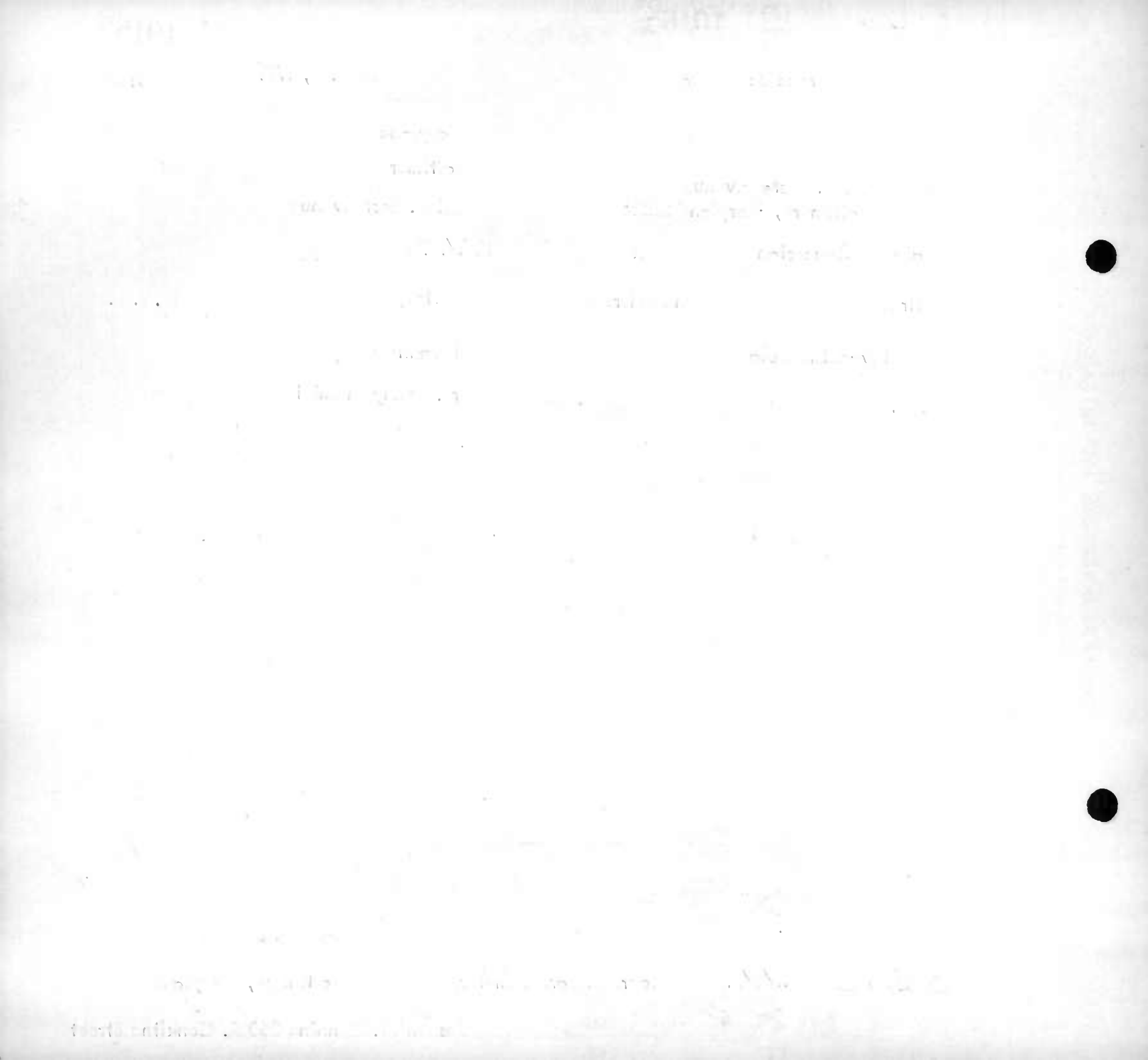
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10164	
BIRTH NO. 71 10164		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Harris, Ellen		2. DATE AND HOUR OF DEATH 10/29/71 3:50 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 807			
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 1502 Rutland Avenue			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/31/10	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Chester Va	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Pearlie Bruce		14. MOTHER'S MAIDEN NAME Estelle Perkins			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-20-3538		17. INFORMANT (Hazel) Harris Porterfield Va	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Cardiogenic arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: COPD, CHF, Acute Symptoms 2 days			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/27 19 71 to 10/29 19 71 that (I) (we) last saw the deceased alive on 10/29 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James E. Kurent		DEGREE M.D.		23B. DATE SIGNED 10/29/71	
23C. PHYSICIAN'S NAME (Type) James Kurent,		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-2-71		24C. NAME of CEMETERY or CREMATORY Mt Carmel Ant	
24D. LOCATION (City, town, or county) (State) Ad County Md		25A. DATE REC'D BY HEALTH DEPT. NOV 4 1971		25B. NAME OF REGISTRAR Robert E. Fahey, M.D.	
25C. FUNERAL DIRECTOR William 1000 Branch St		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

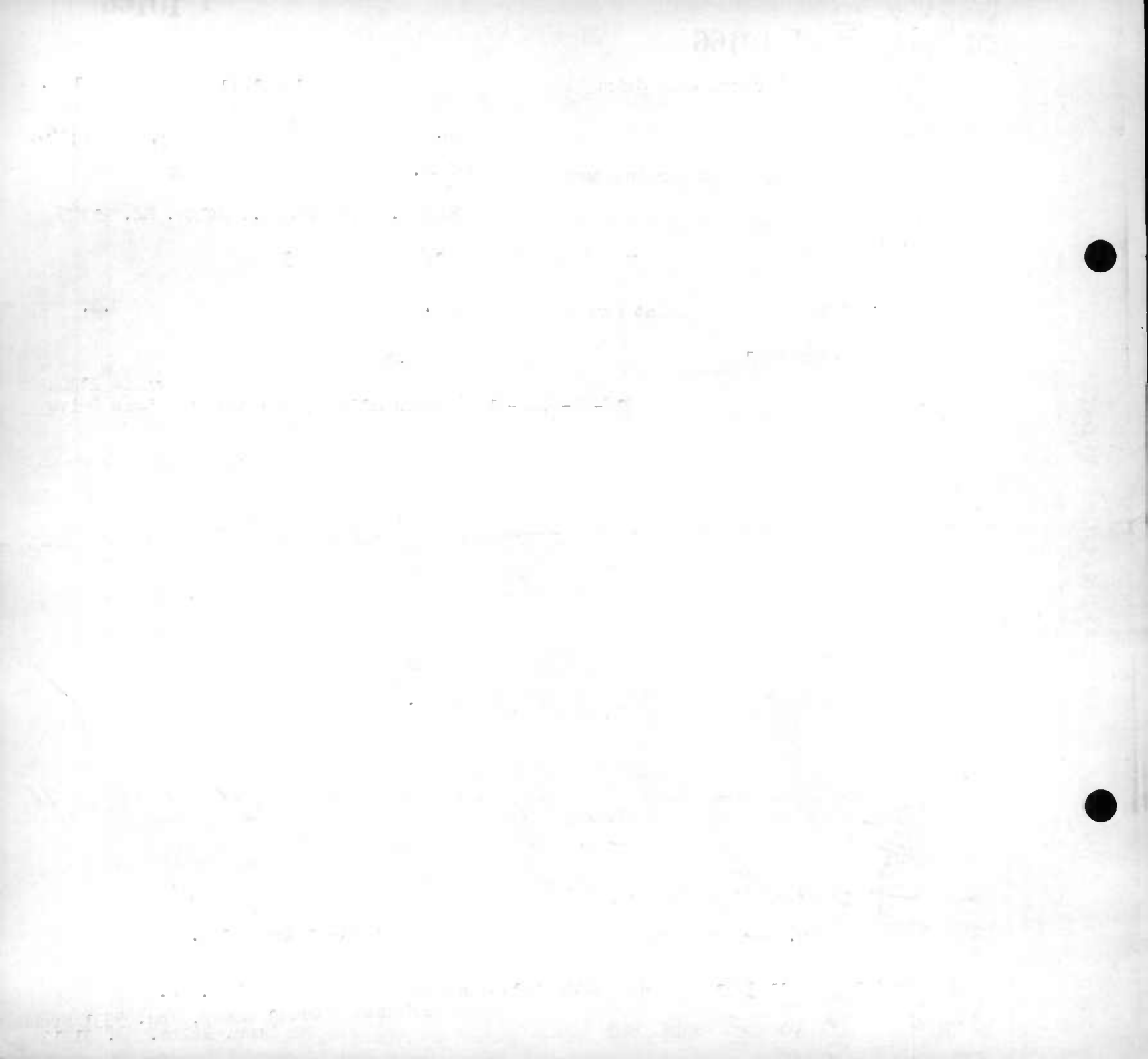
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10165	
C-400 10165		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Francesco Cola		2. DATE AND HOUR OF DEATH Nov. 2, 1971 9:20 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 221 S. East Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2610 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 221 S. East Avenue	
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/1/1878
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Penn Railroad	9. AGE (In years last birthday) 92
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Giovachino Cala		14. MOTHER'S MAIDEN NAME Giovanna -	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. -	17. INFORMANT Mrs. Jenny DiEmidio
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic C.V. Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from FEB. 18 19 49 to Nov 2 19 71 , that (I) lost lost saw the deceased alive on Nov. 2 19 71 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did) not view the body after death.			
23A. SIGNATURE Henry J. Houska MD		23B. DATE SIGNED 11/2/71	
23C. PHYSICIAN'S NAME (Type) HENRY J. HOUSKA MD		23D. ADDRESS 333 S. EAST AVE BALTO. MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 11/6/71	24C. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1971		25B. NAME OF REGISTRAR Robert E. Farber, MD.	25C. FUNERAL DIRECTOR Joseph N. Zannino ADDRESS 263 S. Conkling Street



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 10166	
C-500 10166				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Barbara Anne Caine			10/31/71		1 A. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green Nursing Home			A. STATE		702
			Md.		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			2640 E. Monument St., Balto. Md. 21205		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9/1/78	93	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife		at home		Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Hohl			Mary Spahn		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		218-58-6747-J1		John Callen (Executor) 608 Lake Drive	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			Myocardial Infarction 30 min		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			Arterio Sclerotic Cardio - 5 yrs.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) Vascular Disease		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from 5-23-69 to 10-31-71, 1971, that (I) last saw the deceased alive on SEPT 14, 1971, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Bernard Karpers				11-1-71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Bernard Karpers		Medical Arts Bldg.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/3/71		New Cathedral Cemetery	
				Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 4 1971		Robert E. Farber, MD.		Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO. 10167

1. NAME OF DECEASED (Type or Print) Minna Barrett		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year 10 29 71 Hour 1:05 p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2015 E. Monument St.		3. DATE PRONOUNCED DEAD Month Day Year 10 29 71 Hour 1:05 p M.	
6. SEX female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 9/14/02		10. AGE (In years last birthday) 69	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Program Girl		14B. KIND OF BUSINESS OR INDUSTRY Lowes Central Theatre	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 213-12-2841	
18. INFORMANT B. Baer (Executor)		ADDRESS 21205 2018 E. Monument St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type): Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 10/30/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/2/71	
24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehm Lane, Balto. Md. 21213		ADDRESS	

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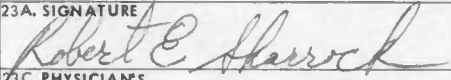
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10168	
5-362 10168 BIRTH NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) STRAUSS, Milton Joseph			2. DATE AND HOUR OF DEATH October 30, 1971 9:45 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 841 841 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3103 Ravenwood Ave.		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-12-94	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired drillpress opr			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Adolph Strauss			14. MOTHER'S MAIDEN NAME Maggie Durrbeck		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5-24-18 to 6-7-19			16. SOCIAL SECURITY NO. 215-03-54-28		
17. INFORMANT Records			ADDRESS VAH, 3900 Loch Raven Blvd Balto., Md. 21218		
18. 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Myocardial Infarction (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Days					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from October 26, 1971 to October 30, 1971, that (X) (we) last saw the deceased alive on October 30, 1971, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) Robert E. Sharrock M.D.			23B. DATE SIGNED 10/30/71 Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 11/2/71		
24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery			24D. LOCATION (City, town, or county) (State) Balto. Md.		
25A. DATE RECD BY HEALTH DEPT. NOV 4 1971			25B. NAME OF REGISTRAR Robert E. Sharrock, M.D.		
25C. FUNERAL DIRECTOR Schlunegger Funeral Homes, Inc.			ADDRESS 3331 Brehms Lane, Balto. Md. 21213		

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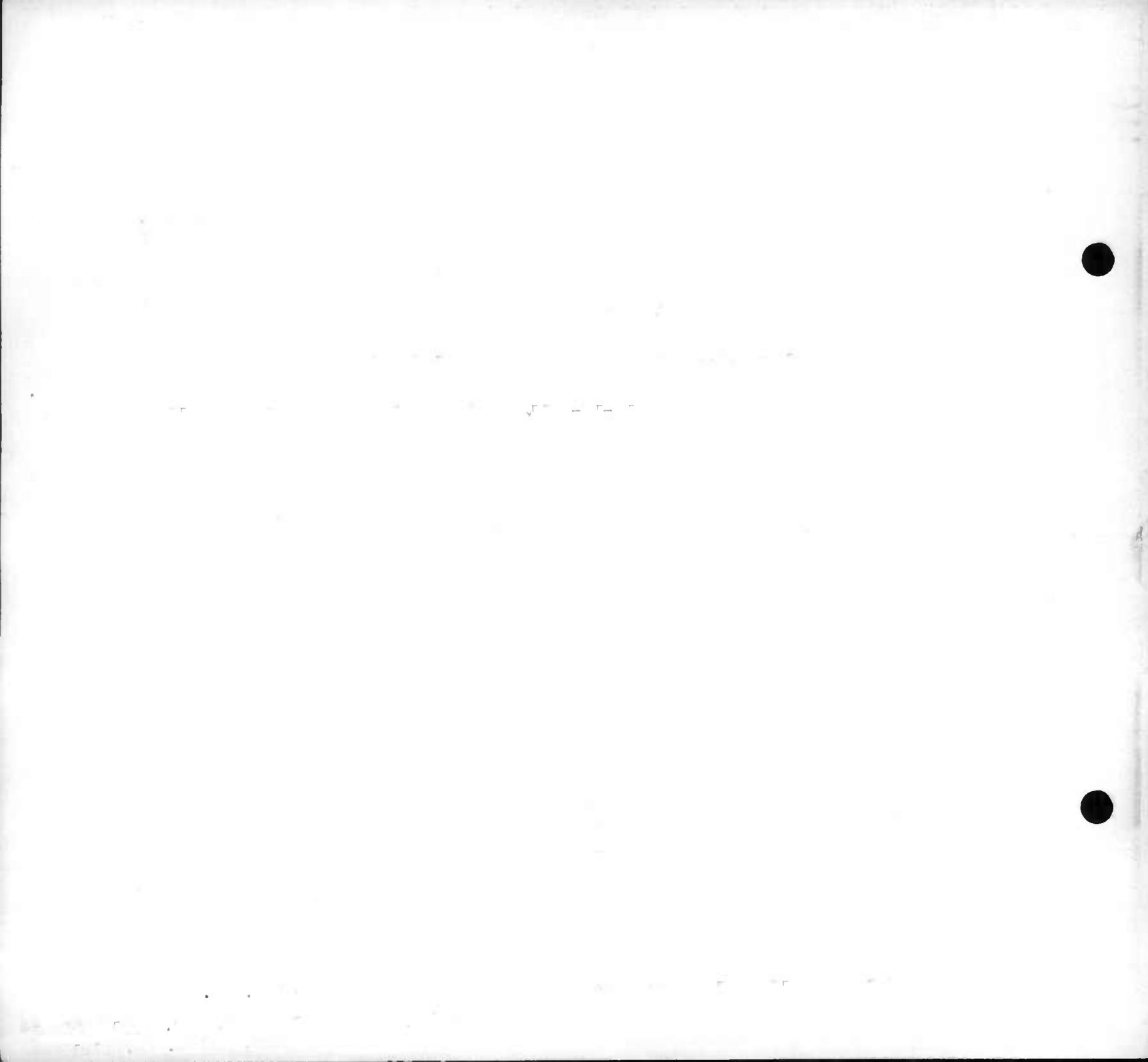
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 10169</u>	
BIRTH NO. <u>S-423 71 10169</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>HELEN SLECHTER</u>		2. DATE AND HOUR OF DEATH <u>10/30/71</u> <u>5:50 AM.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL HOSPITAL</u> <u>827 LINDEN AVE</u> <u>BALTO, MD. 21201</u>		A. STATE <u>MD</u>		B. COUNTY <u>BALTO, CITY</u> <u>2706</u>	
		C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2811 CHRISTOPHER AVE., BALTO, MD 21214</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/9/11</u>	9. AGE (In years last birthday) <u>60</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Charles Beauchamp</u>			
14. MOTHER'S MAIDEN NAME <u>Elsie Fishpaw</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>212-12-6611</u>		17. INFORMANT <u>Albert Slechter (husband)</u> <u>2811 Christopher Ave.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>1-5-7-0-1</u> [This does not mean the mode of dying, e.g., heart failure, ostehenia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Head of Pancreas</u> (B) <u>BRONCHITIS metastases to lung</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>21 NP</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NP</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/23/71</u> 19 to <u>10/30/71</u> 19 that (I) (we) last saw the deceased alive on <u>10/30/71</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>(very recently by Dr. Pawlacz 11/1)</u>					
23A. SIGNATURE <u>P. Middleton</u>				23B. DATE SIGNED <u>10/30/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>P. MIDDLETON</u>				23D. ADDRESS <u>Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21214</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/3/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	
24D. LOCATION <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21214</u>			

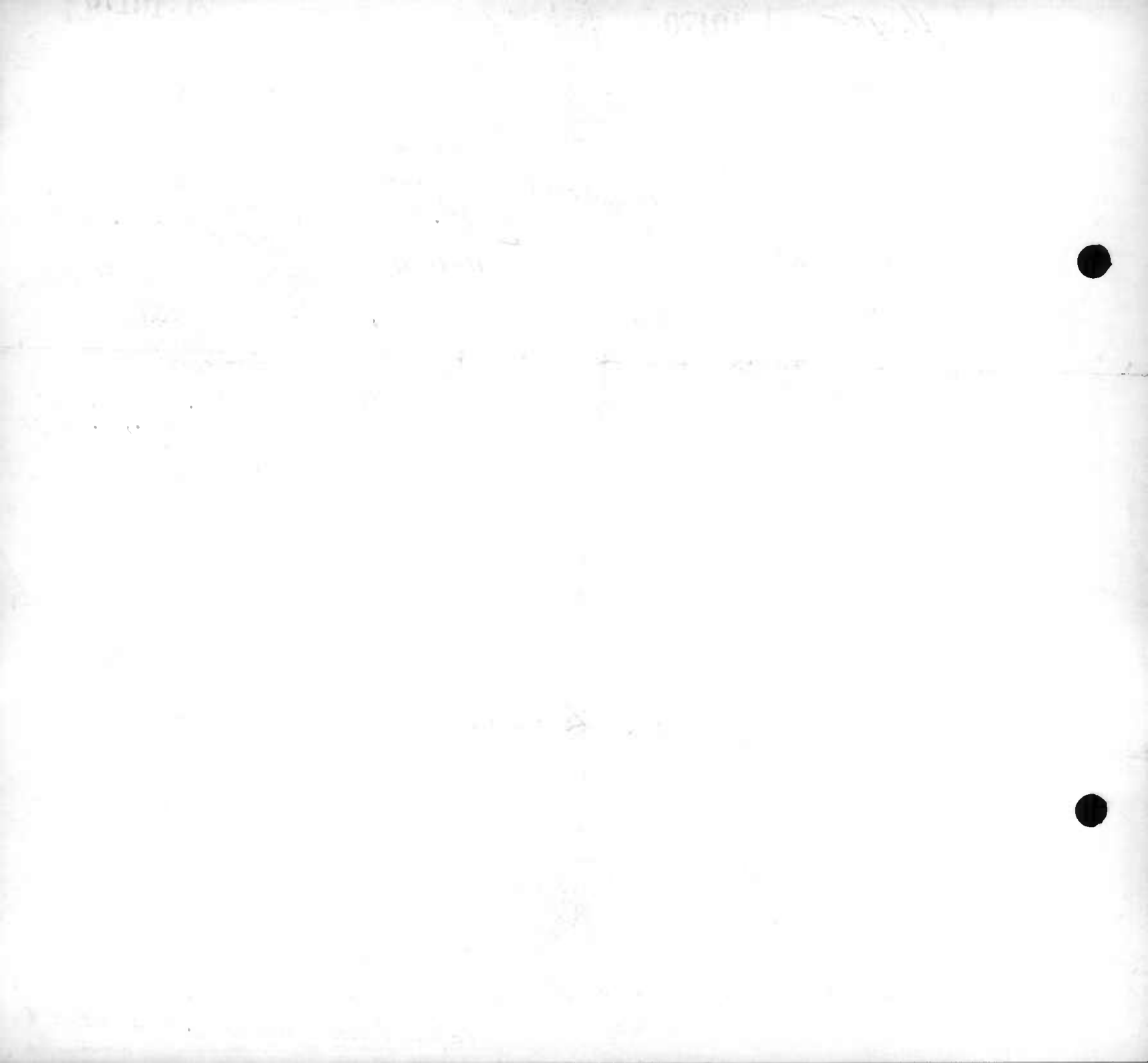


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>10170 4</u>
BIRTH NO. <u>H-455 71 10170</u> <u>71-18174</u>		DATE AND HOUR OF DEATH <u>11-2-71</u> <u>140 P.M.</u>		
1. NAME OF DECEASED (Type or Print) <u>Holleman Baby Boy</u>		2. DATE AND HOUR OF DEATH		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2303</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore General Hospital</u> <u>43</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u> 6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-1-71</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		9. AGE (In years last birthday) <u>31</u> 11 Under 1 Yr. Months <u>11</u> Days <u>17</u>
13. FATHER'S NAME <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Holleman</u>
17. INFORMANT <u>CHART</u> (Signature) <u>Hazel Holleman</u> ADDRESS <u>8 W. Barney Street Baltimore, Md. 21220</u>		18. CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>2269 I</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Prematurity (33 wks gestation) 31 hours</u> (1276 gm)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Neonatal asphyxia</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>Atelectasis of left lung 31 hours</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>11/1 6:23 AM</u> 19 <u>71</u> to <u>11/2 1:40 PM</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11/2</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Delgic M.D.</u>		23B. DATE SIGNED <u>11/2 71</u>		23C. PHYSICIAN'S NAME (Type) <u>CRGIC</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/4/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>		25C. FUNERAL DIRECTOR <u>McCully Funeral Home</u> ADDRESS <u>130 E. Fore Avenue</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

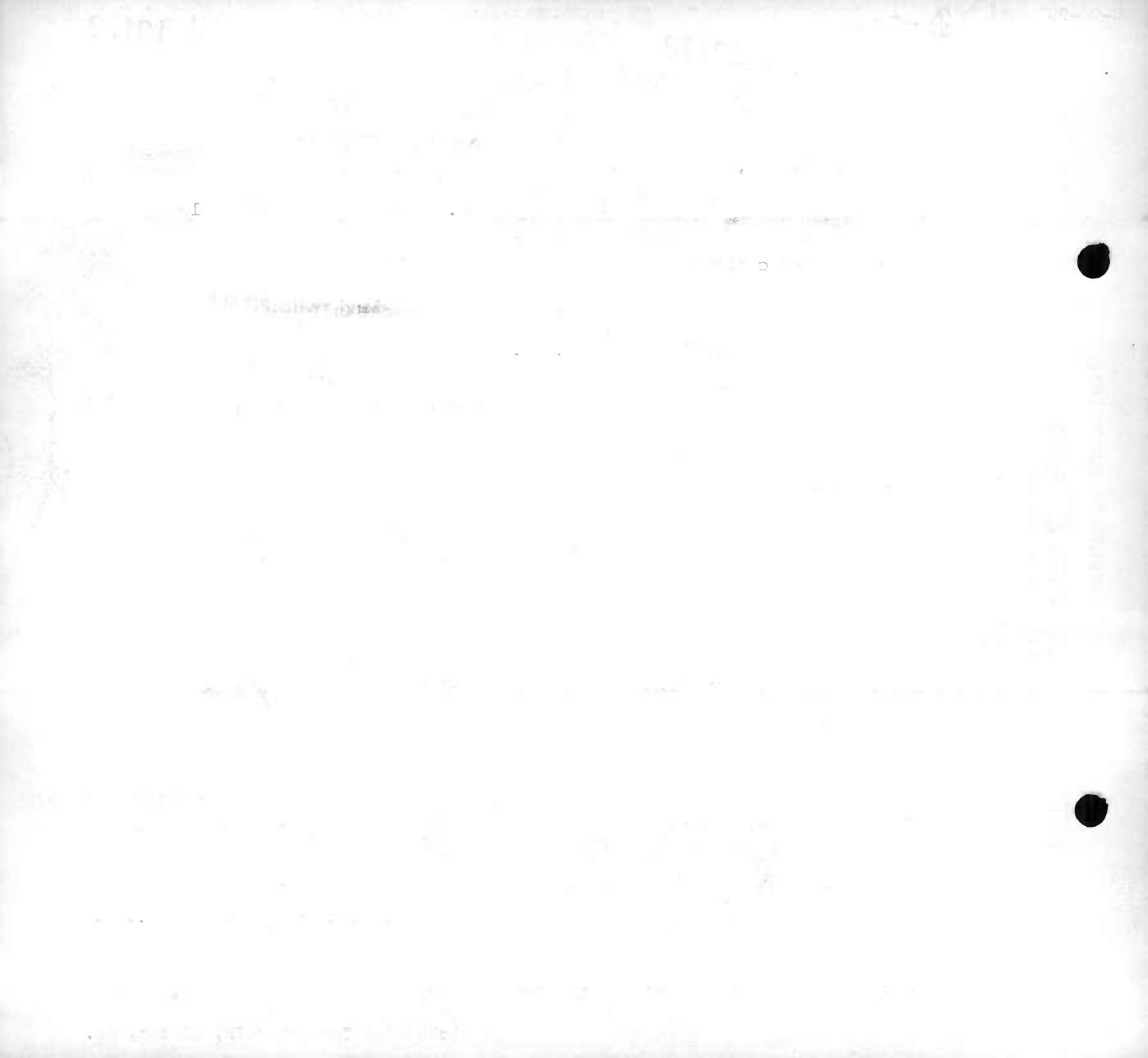
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10171</u>	
BIRTH NO. <u>K-352 71 10171</u>					
1. NAME OF DECEASED (Type or Print) <u>John W. Keating</u>		2. DATE AND HOUR OF DEATH <u>10-30-71</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>005009 Belleville Ave</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>2802</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>5009 Belleville Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-4-1905</u>	9. AGE (In years last birthday) <u>66</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tire Maker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>John W. Keating</u>		14. MOTHER'S MAIDEN NAME <u>-</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-9763</u>		17. INFORMANT <u>Elizabeth S Keating - Same</u>	
18. <u>5-19-31</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>CHRONIC COR PULMONALE</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CHRONIC OBSTRUCTIVE LUNG DISEASE</u>		<u>7 years</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		<u>? year</u>	
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<u>NONE</u>			
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10-23-71</u> 19 <u>71</u> to <u>10-30</u> 19 <u>71</u> that (I) (was) last saw the deceased alive on <u>10-30</u> 19 <u>71</u> and that in (my) (was) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sam Osلمان</u>				23B. DATE SIGNED <u>10-1-71</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <u>5407 GWYNN OAK AVE 21207</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>11-3-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Garber, M.D.</u>	
25C. FUNERAL DIRECTOR <u>ARMACOST FUNERAL Chapel - 4600 Liberty Hgts.</u>		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

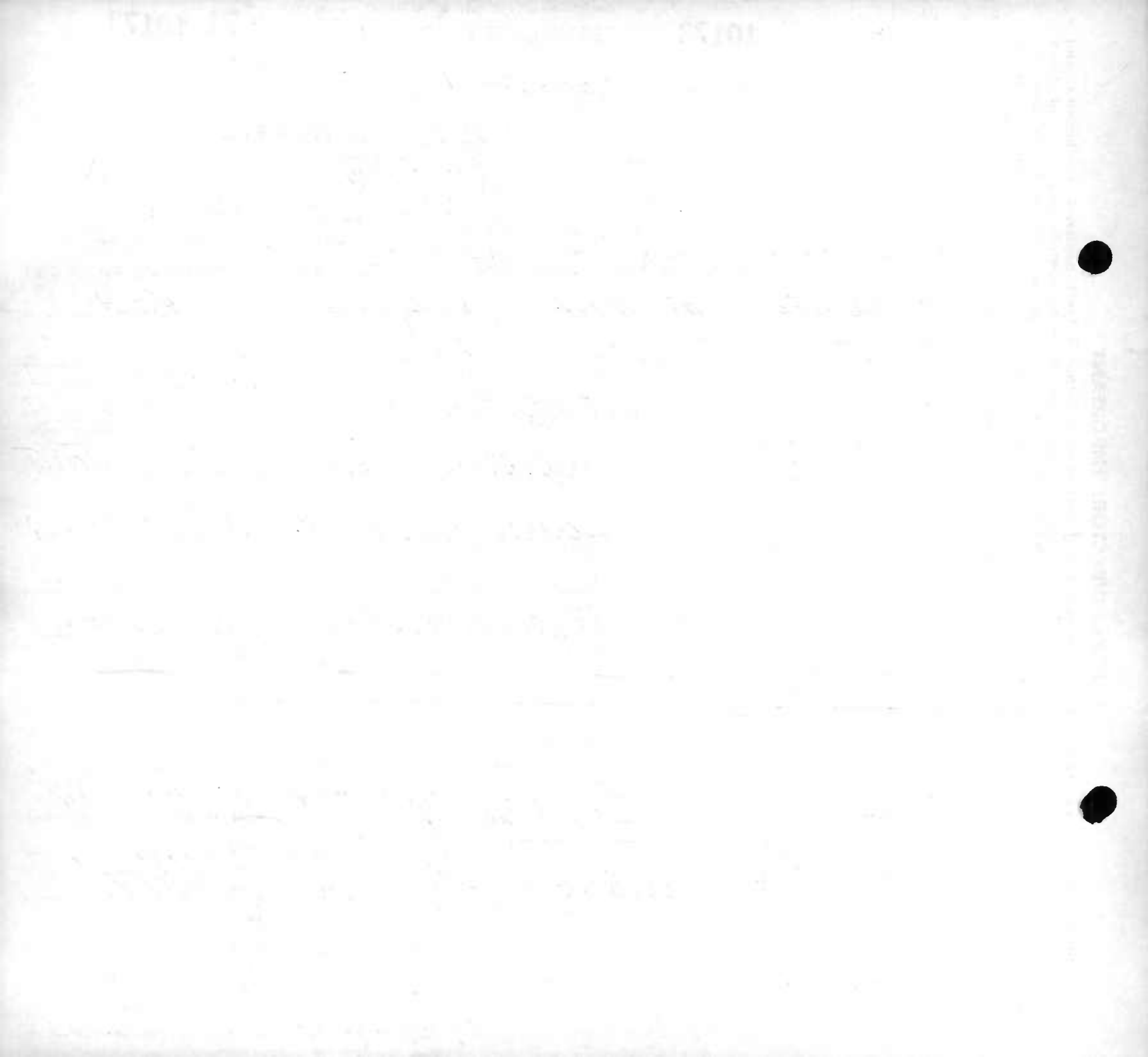
<p>BIRTH NO. <u>10172</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>Baby Girl Main</u></p>				<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p> <p>REG. NO. <u>71 10172</u></p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>Baltimore City Hospital</u> <u>4940 Eastern Avenue</u></p>				<p>2. DATE AND HOUR OF DEATH</p> <p><u>10/31/71</u> <u>12:05 A.</u> M.</p>			
<p>5. SEX <u>Female</u> 6. RACE <u>Caucasian</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>				<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</p> <p>A. STATE <u>Maryland</u> B. COUNTY <u>Cecil</u></p>			
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>				<p>C. CITY OR TOWN <u>Elkton</u></p>		<p>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>13. FATHER'S NAME <u>Earl Grant Main, JR.</u></p>				<p>E. STREET AND NUMBER <u>Rt. 3 Box 356</u></p>		<p>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>				<p>6. DATE OF BIRTH <u>10/29/71</u></p>		<p>9. AGE (In years last birthday) <u>46</u></p>	
<p>16. SOCIAL SECURITY NO.</p>				<p>11. BIRTHPLACE (State or foreign country) <u>Maryland</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>17. INFORMANT <u>4940 Eastern Avenue</u> ADDRESS</p>				<p>BCH-Records <u>Baltimore, Maryland 21224</u></p>			
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>							
<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u></p>							
<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory Insufficiency</u></p>							
<p>(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u></p>							
<p>(C) _____</p>							
<p>19A. DATE OF OPERATION <u>2</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____</p>							
<p>20A. AUTOPSY? (Yes or No) <u>YES</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u></p>							
<p>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)</p>				<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>			
<p>21C. WHERE DID INJURY OCCUR? _____ (If in Baltimore City, give exact location)</p>				<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) _____</p>			
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>				<p>21F. HOW DID INJURY OCCUR? _____</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from <u>10/31/71 4:45 PM</u> to <u>10/31/71 12:05 AM</u> that (I) (we) last saw the deceased alive on <u>10/31/71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>							
<p>23A. SIGNATURE <u>Alan R. Green M.D.</u></p>				<p>23B. DATE SIGNED <u>10/31/71</u></p>			
<p>23C. PHYSICIAN'S NAME (Type) <u>ALAN R. GREEN M.D.</u></p>				<p>23D. ADDRESS <u>4940 Eastern Avenue Baltimore, Md. 21224</u></p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>11/2/71</u></p>		<p>24C. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cemetery</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Union, Cecil Co. Maryland</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1971</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Talley, M.D.</u></p>		<p>25C. FUNERAL DIRECTOR <u>Ralph E. Hicks</u></p>		<p>ADDRESS <u>Hicks Home for Funerals, Elkton, Md.</u></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

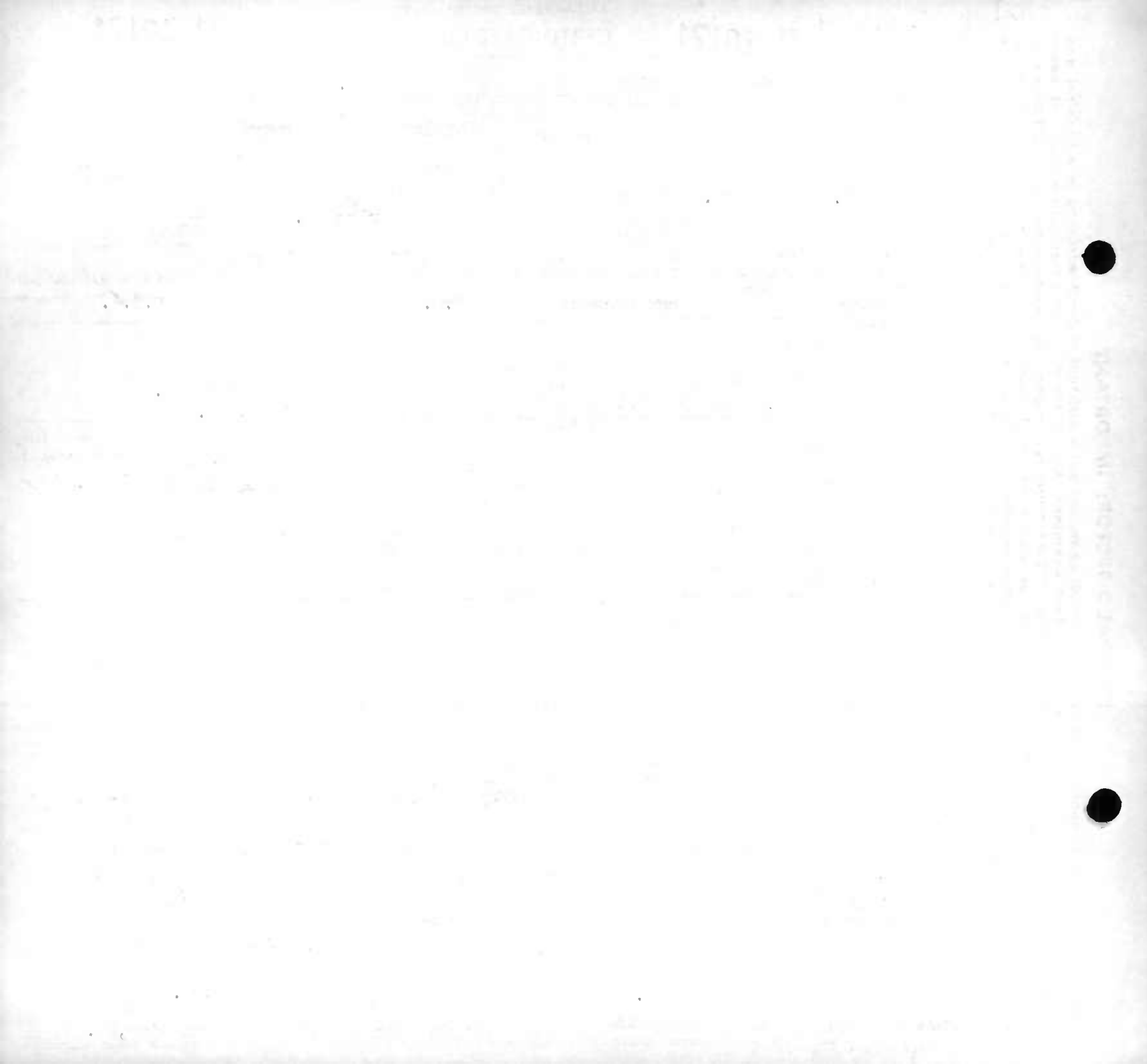
M-263 71 10173		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 10173	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>SADIE MAY Mcgruden</i>			
2. DATE AND HOUR OF DEATH <i>OCT 31, 1971</i>				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>SOUTH BALTO. GEN HOSP.</i> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <i>D.O.A.</i>				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <i>MD</i> B. COUNTY <i>HOWARD</i> C. CITY OR TOWN <i>ELICOTT CITY</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>10176 Old Frederick Rd.</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAR 4 1893</i>	9. AGE (In years last birthday) <i>78</i>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>ALBERT DERFLINGER</i>				14. MOTHER'S MAIDEN NAME <i>EMMA GOODE</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>579-20-0151</i>		17. INFORMANT <i>BENJ SMOOT</i>		ADDRESS <i>10176 Old Frederick Rd Elicott City, Md 21043</i>	
18. <i>4 10 9 1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Thrombosis instant</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>	
(B) <i>Chronic heart dis.</i>				(C) <i>Peptic Ulcer</i>		<i>3 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>NO</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 30 1971</i> to <i>Oct 31 1971</i> and that (I) (we) last saw the deceased alive on <i>Sept 30 1971</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Cordelia M. ...</i>				23B. DATE SIGNED <i>11/1/71</i>			
23C. PHYSICIAN'S NAME (Type) <i>HOWARD COUNTY MEDICAL CENTER</i>				23D. ADDRESS <i>3459 ST. JOHNS LANE</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11-3-71</i>		24C. NAME OF CEMETERY <i>MT VIEW</i>		24D. LOCATION (City, town, or county) (State) <i>MARRIOTTVILLE MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 4 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Higginbotham-Slack</i>		ADDRESS <i>ELICOTT CITY MD 21043</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 10174</u>	
S-460 BIRTH NO. <u>71 10174</u>		1. NAME OF DECEASED (Type or Print) <u>Jack Sholar</u>		2. DATE AND HOUR OF DEATH <u>Oct. 29 1971</u> <u>11 0</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>St. Agnes Hosp. (DOA)</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Howard</u> <u>6300</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>401 99</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Elkridge</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>6409 Waterloo Rd.</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/15/1930</u>	9. AGE (in years lost birthday) <u>41</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lacy Sholar</u>				14. MOTHER'S MAIDEN NAME <u>Annie Lanier</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>Oct 51</u> , <u>Oct 53</u>		16. SOCIAL SECURITY NO. <u>241 44 7056</u>		17. INFORMANT <u>Ruth Sholar</u> ADDRESS <u>6409 Waterloo Rd. Elkridge, Md. 21227</u>			
18. <u>171.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>terminal Rhaldo Myo</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>General metastasis</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Sarcocoma of hip</u> (B) <u>General metastasis</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>about 7 mos</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>Sept 27 1971</u> to <u>Oct 29 1971</u> that (I) (we) last saw the deceased alive on <u>Oct 27 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. <u>DOA at St Agnes Hosp</u>							
23A. SIGNATURE <u>Bruce Brumbaugh</u>				23B. DATE SIGNED <u>11/1/71</u>		23C. PHYSICIAN'S NAME (Type) <u>B BRUCE BRUMBAUGH MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>11/1/1971</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Johns Lutheran</u>		24D. LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Higinbotham Slack</u>		ADDRESS <u>Ellicott City, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10175</u>
<p><u>L-616</u> <u>71 10175</u></p> <p>BIRTH NO.</p>		<p>1. NAME OF DECEASED (Type or Print) <u>Carolyn M. Lorber</u></p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>00 2712 E. Madison St</u></p>		<p>2. DATE AND HOUR OF DEATH <u>Nov. 1 1971</u> <u>7 P.</u> M.</p> <p>4. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission)</p> <p>A. STATE <u>md</u> B. COUNTY <u>702</u></p> <p>C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>2712 E. Madison St. Balto 5</u></p>		
<p>5. SEX <u>Female</u></p>	<p>6. RACE <u>White</u></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>		<p>8. DATE OF BIRTH <u>6/14/99</u> 9. AGE (in years last birthday) <u>72</u></p>		
<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <u>Maryland</u></p>		
<p>13. FATHER'S NAME <u>James Smutny</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Francis Jiricek</u></p>		
<p>6. SOCIAL SECURITY NO. <u>213 019353 B</u></p>		<p>17. INFORMANT ADDRESS <u>Andrew Lorber 2712 E. Madison</u></p>		
<p>18. <u>182.9 I</u> CAUSE OF DEATH</p>				
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p><u>Uterine Cancer</u></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p>				
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>				
<p>II</p>				
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> <p><u>Gen Abd Metastasis</u></p>				
<p>19A. DATE OF OPERATION <u>0</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>		
<p>22. I certify that (1) (this hospital) attended the deceased from <u>5-26-70</u> 19<u>71</u> to <u>11-1</u> 19<u>71</u> that (1) (we) last saw the deceased alive on <u>10-30</u> 19<u>71</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.</p>				
<p>23A. SIGNATURE <u>Theodore T. Niznik</u></p>				<p>23B. DATE SIGNED <u>11-2-71</u></p>
<p>23C. PHYSICIAN'S NAME (Type) <u>T. T. NIZNIK</u></p>				<p>23D. ADDRESS <u>429 S Chester St 21231</u></p>
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>11/4/71</u></p>		
<p>24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Balto Md</u></p>		
<p>25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1971</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Tabor, M.D.</u></p>		
<p>25C. FUNERAL DIRECTOR <u>Philip G. Crach</u></p>		<p>25D. ADDRESS <u>1211 Chesaco Ave</u></p>		

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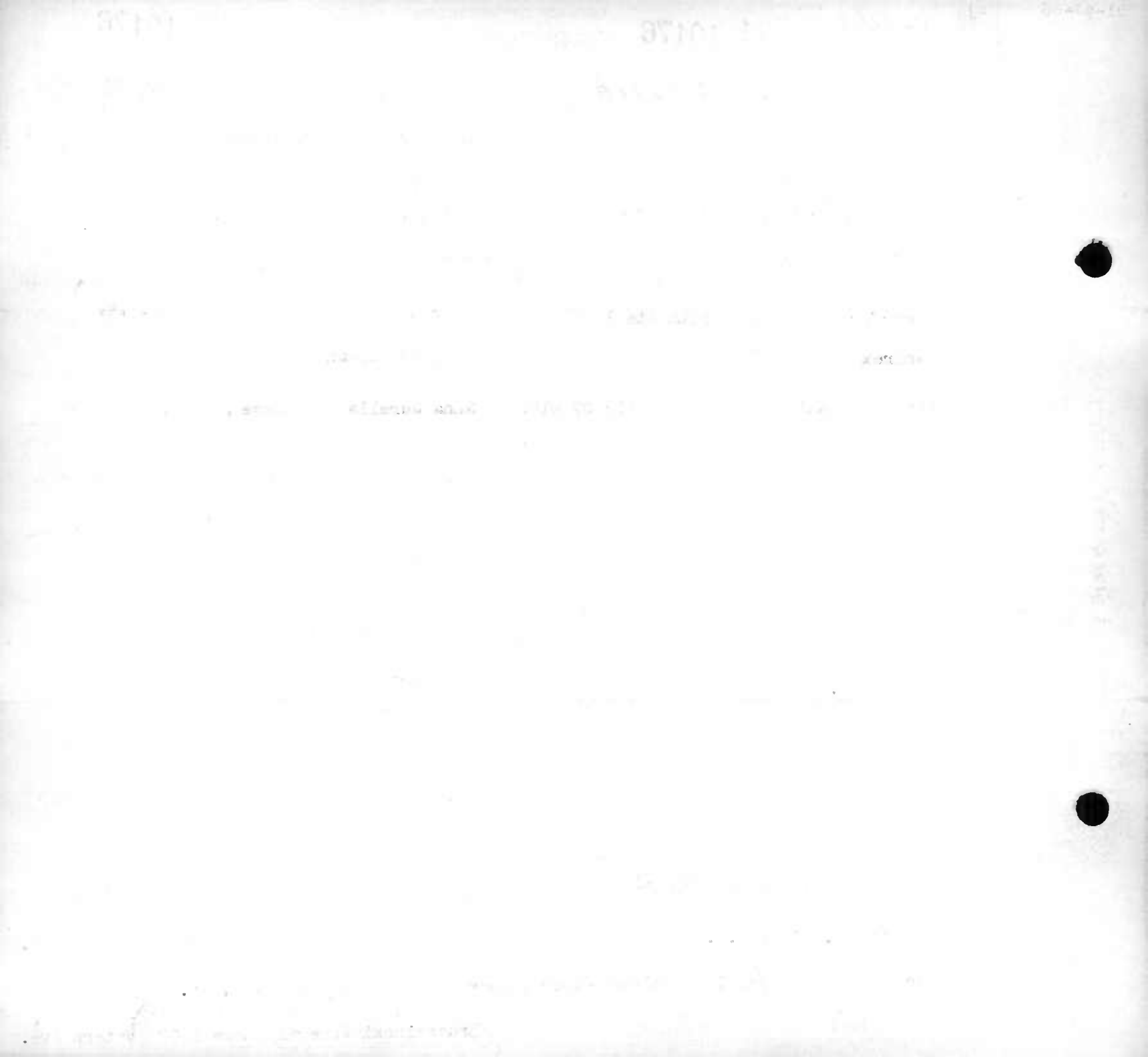
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-640		71 10176		BALTIMORE CITY HEALTH DEPARTMENT		X		71 10176	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
		STEPHEN JURELLA		Nov. 1, 1971		8:35 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland		B. COUNTY Baltimore		5300	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER 8 Riverside Road		21221			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-4-99	9. AGE (in years last birthday) 71	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scarfier			10B. KIND OF BUSINESS OR INDUSTRY Beth Steel			11. BIRTHPLACE (State or foreign country) Penna.			12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Andrew Jurella				14. MOTHER'S MAIDEN NAME Sophie Doman					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 213 07 9140		17. INFORMANT Anna Jurella		ADDRESS Same, Maryland 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH acute disseminated (A) IMMEDIATE CAUSE myelomonocytic leukemia DUE TO, OR AS A CONSEQUENCE OF: disseminated, metastatic, hepatoma (B) DUE TO, OR AS A CONSEQUENCE OF: (C) anterior myocardial infarction 15 yrs ago bronchitis; laryngeal carcinoma 15 years ago				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 1/2 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Nov. 1 1971 to Nov. 1 1971 that (I) (we) lost saw the deceased alive on Nov. 1 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE John W. Kirk, M.D.				23B. DATE SIGNED Nov. 1, 1971					
23C. PHYSICIAN'S NAME (Type) John W. Kirk, M.D.				23D. ADDRESS Baltimore City Hospital		4940 Eastern Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/5/71		24C. NAME of CEMETERY or CREMATORY Galene Funeral Home		24D. LOCATION (City, town, or county) (State) Mount Pleasant, Pa.			
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1971		25B. NAME OF REGISTRAR Robert E. Tabor, R.D.		25C. FUNERAL DIRECTOR Bruzdzinski Funeral Home		ADDRESS 1407 Eastern Ave.			



E-6251 10177

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 10177

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) PAUL ERIKSON Ericson		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 906 N. Calvert St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 31 1971 10:48p.m.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 4/20/46		10. AGE (In years last birthday) 25	
11. BIRTHPLACE (State or foreign country) Balto Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Orville C.		14. MOTHER'S MAIDEN NAME Violet F. Deal	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labour		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. 304.91		CAUSE OF DEATH Intravenous narcotism	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11-1-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/3/71	
24C. NAME OF CEMETERY or CREMATORY Moulton		24D. LOCATION (City, town, or county) (State) 6067 Harford Rd	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1971		25B. NAME OF REGISTRAR Robert S. Fisher, M.D.	
25C. FUNERAL DIRECTOR W. Deermann		ADDRESS 6067 Harford Rd	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-310 BIRTH NO.		71 10178		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		71 10178 REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
STEPPE, PAUL ALEXANDER Sr.				NOVEMBER 2, 1971		7:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY			
ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTIMORE, MD. 21229				MARYLAND		BALTO.		5300	
C. CITY OR TOWN				D. INSIDE CITY LIMITS?					
BALTIMORE				YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER				617 ORPINGTON ROAD		21229			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		11-01-06		65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
RETIRED CLERK		R.S. STERN		NORTH CAROLINA		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
BENJAMIN STEPPE DEC'D				SALLY (LYLE) DEC'D					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		245012366		ST. AGNES HOSPITAL, WLLKENS & CATON AVE.					
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Ca of the Colon</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Generalized Regional metastasis</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR					
22. I certify that (I) (this hospital) attended the deceased from		OCTOBER 29		19 71 to		NOVEMBER 2		19 71	
that (I) (we) last saw the deceased alive on		NOVEMBER 2		19 71 and that in (my) (our) opinion death occurred on the date		and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE				23B. DATE SIGNED					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
ANTONY, M.D.									
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		11/4/1971		Lorraine Park Cemetery		Baltimore County, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
NOV 4 1971		Robert E. Taylor, M.D.		G. Truman Schwab		5151 Balto. Nat'l Pike			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-260 71 10179		BALTIMORE CITY HEALTH DEPARTMENT		71 10179	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mrs. PEARL V. JAI GER		NOV, 4th 1971 2. 15 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 44 THE UNION MEMORIAL HOSPITAL			A. STATE MARYLAND BALT. CITY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER WYMAN PARK APTS APT 411		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-77	9. AGE (In years last birthday) 94	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - HOME MAKER			11. BIRTHPLACE (State or foreign country) W. VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM H. BROOKS			14. MOTHER'S MAIDEN NAME ELIZA JANE BRYANT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 218-03-3220		17. INFORMANT BEULAH WELLSNER
			ADDRESS 116 W. UNIVERSITY PKWY.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
			IMMEDIATE CAUSE RESPIRATORY FAILURE		48 hours.
			DUE TO, OR AS A CONSEQUENCE OF: CVA FRACTURED (R) HIP.		19 DAYS
			DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease		
19A. DATE OF OPERATION OCT. 27 - 1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURED (R) HIP		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) WYMAN PARK APTS APT 411	
21D. TIME OF INJURY (I Approx) OCTOBER 17 1971		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELL	
22. I certify that (this hospital) attended the deceased from OCT. 17 1971 to NOV. 4th 1971 that (we) last saw the deceased alive on NOV. 4th 1971 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Juan H. Serrano				23B. DATE SIGNED NOV - 4th 1971	
23C. PHYSICIAN'S NAME (Type) JUAN H. SERRANO M.D.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 11-6-71		24C. NAME of CEMETERY or CREMATORY Lorraine Mausoleum	
				24D. LOCATION (City, town, or county) (State) Baltimore, Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1971		25B. NAME OF REGISTRAR R. E. J. J. J.		25C. FUNERAL DIRECTOR H. W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 10180

BIRTH NO. <u>Bullock, B. A. B.</u>		10180	
1. NAME OF DECEASED (Type or Print) <u>BABY</u>		2. DATE AND HOUR OF DEATH <u>October 27, 1971</u> <u>9:20 P. M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Bullock Girl, Christine (B)</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1503</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u> 6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Michael</u>		14. MOTHER'S MAIDEN NAME <u>Christine Fulbrook</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>BCH: Records Baltimore, Maryland 21224</u>		ADDRESS <u>4940 Eastern Avenue</u>	
18. <u>769.4 I</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardio - respiratory arrest</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Severe P. rematensis</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) <u>Multiple Pregnancy</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10-27</u> <u>19</u> <u>71</u> to <u>10-27</u> <u>19</u> <u>71</u> that (I) (we) last saw the deceased alive on <u>10-27</u> <u>19</u> <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Asuncion Disini M.D.</u>		23B. DATE SIGNED <u>10-27-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>ASUNCION DISINI M.D.</u>		23D. ADDRESS <u>Baltimore City Hospital Balto. Md 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>10-29-71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore City Hospitals</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland 21224</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>	
25C. FUNERAL DIRECTOR		ADDRESS	

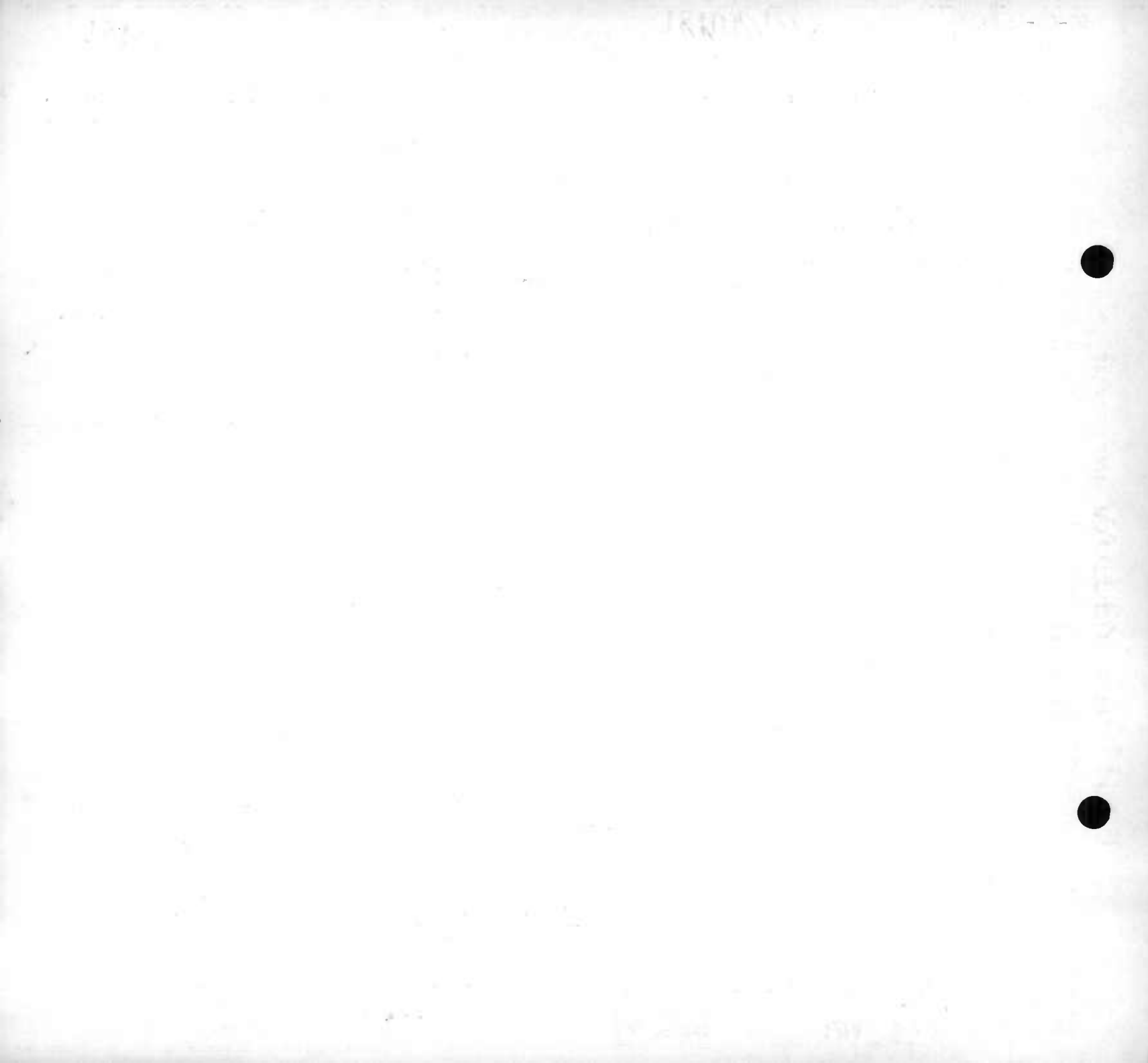
HOSPITAL DISPOSAL



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 10181</u>	
BIRTH NO. <u>B-4203-11-18729</u> <u>10181</u>					
1. NAME OF DECEASED (Type or Print) <u>Bullock, Girl, Christine (A)</u>			2. DATE AND HOUR OF DEATH <u>October 27, 1971</u> <u>8:00 A. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1503</u>		
5. SEX <u>Female</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <u>10-27-71</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Michale</u>	
14. MOTHER'S MAIDEN NAME <u>Christine Fulwood</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>BCH:RECORDS Baltimore, Maryland 21224</u>		ADDRESS <u>4940 Eastern Avenue</u>		18. CAUSE OF DEATH	
18a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>769.4 I</u> <u>Cardio-respiratory arrest</u>		18b. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Severe prematurity</u> <u>Multiple pregnancy</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10-27</u> <u>1971</u> to <u>10-27</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>10-27</u> <u>1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Asuncion Disini, M.D.</u>				23B. DATE SIGNED <u>10-27-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>ASUNCION DISINI M.D.</u>				23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Balto. Md. 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>10-29-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore City Hospitals</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. STATE <u>21224</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 4 1971</u>	
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL ADDRESS		25D. HOSPITAL DISPOSAL ADDRESS	



1

D-540 71 10182

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 71 10182

BIRTH NO. REG. NO.

1. NAME OF DECEASED (Type or Print) Maurece Daniel		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 9 15 71 11:13 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 15 71 11:13 P.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10. AGE (In years lost birthday) 38		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country)		E. STREET AND NUMBER 900 E. Eager Street	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. 571.8 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 9-16-71			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 10-29-71	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS	

VS 151-REV. 1/1/68

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

SI 1018

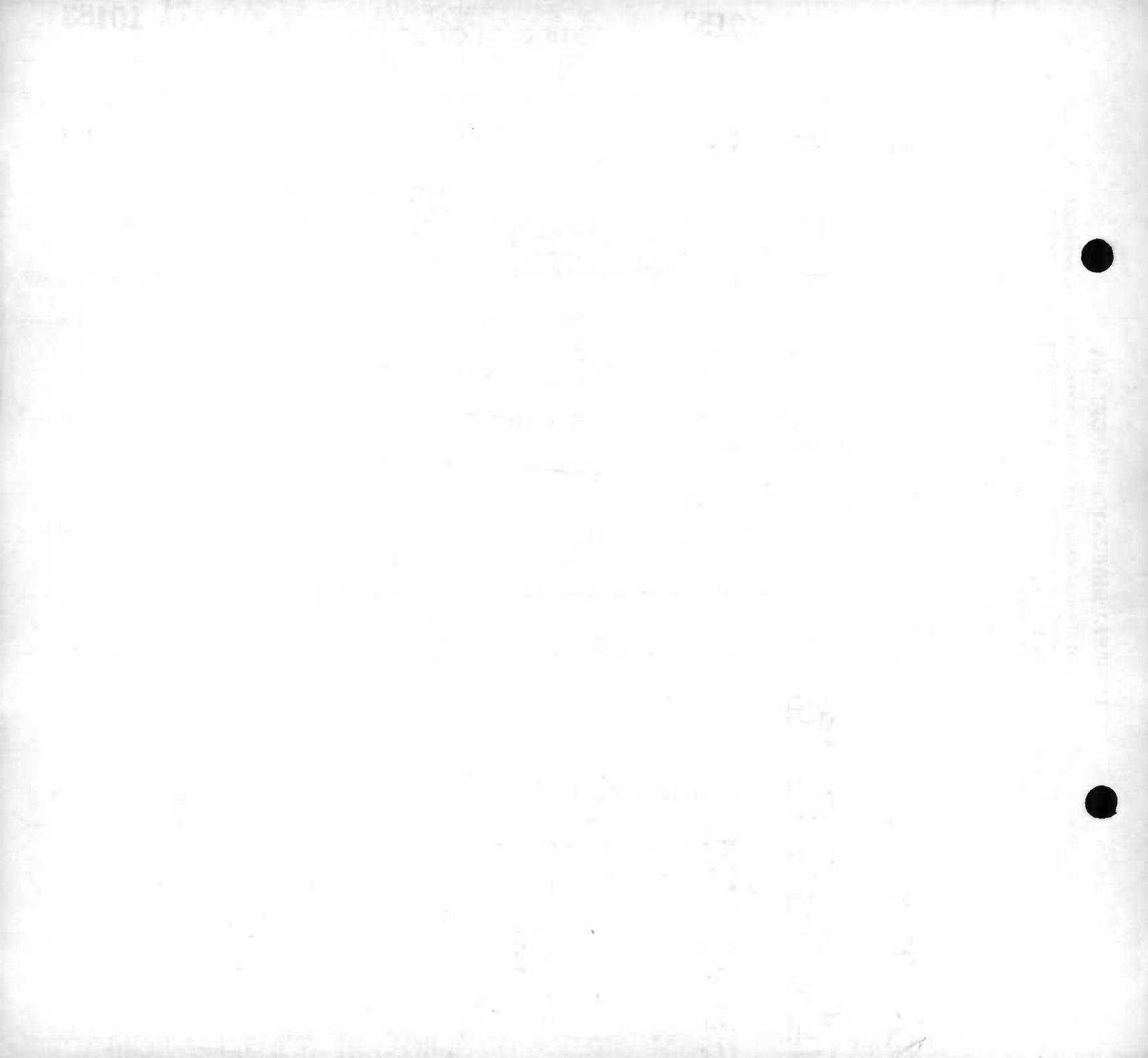
SI 1018

ACADEMY BOOK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-235 71 10183		BALTIMORE CITY HEALTH DEPARTMENT		71 10183	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) VICTOR GUSTINE		2. DATE AND HOUR OF DEATH 10/30/71 9:25 am M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL 37		A. STATE MARYLAND B. COUNTY 301			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 451 S. CAROLINE ST			
5. SEX MALE	6. RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-14-18	9. AGE (in years last birthday) 53	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) TEXAS	
13. FATHER'S NAME WEBSTER GUSTINE		14. MOTHER'S MAIDEN NAME DRILLA SIMPSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 136X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST HYPOXIA (B) DUE TO, OR AS A CONSEQUENCE OF: INFECTION (C) MORBID OBESITY.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 55 MINUTES 4-945 20+ yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 10/19/71 to 10/29/71 that (we) last saw the deceased alive on 10/29/71 and that (we) (our) opinion death occurred on the date and hour and from the causes stated above (We) (did) (did not) view the body after death.					
23A. SIGNATURE J M Parodo MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10/30/71	
23C. PHYSICIAN'S NAME (Type) JUAN M. PARODO		23D. ADDRESS MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) 11-2-71		24B. DATE		24C. NAME of CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR ADDRESS UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	



1

C-500 71 10184

BALTIMORE CITY HEALTH DEPARTMENT

71 10184

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Richard Chaney		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> Month 10 Day 9 Year 1971 Hour 4:00 AM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital 2-7-72		3. DATE PRONOUNCED DEAD Month 10 Day 9 Year 1971 Hour 4:20 AM	
6. SEX Male		7. RACE White <input checked="" type="checkbox"/> Colored <input type="checkbox"/>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		10. AGE (in years, lost birthday) 60	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. E890X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carbon monoxide poisoning (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: Pulmonary emphysema		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1412 S. Hanover Street 2301		22F. HOW DID INJURY OCCUR? inhalation of smoke & soot incident to conflagration	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 10 9, 1971 3:45AM		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE [Signature] Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10/9/71 EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 10-29-71	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 4 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

2-7-1972 - Letter - Office of the Chief Medical Examiner - Werner U. Spitz, M.D.
Deputy Chief Medical Examiner

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 10185</u>	
CERTIFICATE OF DEATH					
BIRTH NO. <u>M-460</u>		71 10185			
1. NAME OF DECEASED (Type or Print) <u>LUTHER P MILLER</u>			2. DATE AND HOUR OF DEATH <u>Dec Nov 1971</u> <u>7:40 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Hood Nursing Home</u> <u>North Bend & Edmondson Avenue</u>			A. STATE <u>Maryland</u> B. COUNTY <u>2864</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>8 N. Woodington Road</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/5/81</u>	9. AGE (In years last birthday) <u>89</u>	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	11. BIRTHPLACE (State or foreign country) <u>Lovettsville, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Patrick Henry</u>			14. MOTHER'S MAIDEN NAME <u>Anna Rex</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-09-0721</u>		17. INFORMANT ADDRESS <u>Emile B. Miller 8 N. Woodington Rd. 21229</u>	
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Alters schenke CVD</u> (B) <u>Alters schenke Disease (Bursitis) 10 yrs.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Prostatic Hypertrophy</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 19</u> 19 <u>70</u> to <u>Nov 2</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Nov 2</u> 19 <u>71</u> and that (in my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.					
23A. SIGNATURE <u>Dr. J. Nelson McKay</u>			23B. DATE SIGNED <u>2 Nov. 1971</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. J. Nelson McKay</u>			23D. ADDRESS <u>6014 Edmondson Avenue</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/5/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven</u>	
24D. LOCATION <u>Glen Burnie, Maryland</u>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Witzke, 1630 Edmondson Avenue 21228</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10186	
N-620-18564 10186		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Norris, B. Girl		2. DATE AND HOUR OF DEATH Nov. 1, 1971 9:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 804	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 2102 E. Hoffman Street	
5. SEX F	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-1-71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday)	11. BIRTHPLACE (State or foreign country) Johns Hopkins Hospital Baltimore, Maryland
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME ALLEN B. MURRAY
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT LEOLA NORRIS
18. 426X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH SEVERE METABOLIC ACIDOSIS (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SEVERE HYPOXIA (B) DUE TO, OR AS A CONSEQUENCE OF: PRIMARY PULMONARY HYPERTENSION (C) present at birth	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOV 1 19 71 to NOV 1 19 71 that (I) (we) last saw the deceased alive on NOV 1 19 71 and that (in my) opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.			
23A. SIGNATURE Thomas G. Quattlebaum MD		23B. DATE SIGNED NOV 1, 1971	
23C. PHYSICIAN'S NAME (Type) THOMAS G. QUATTLEBAUM MD		23D. ADDRESS 601 N. BROADWAY, BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 11/2/71	
24C. NAME OF CEMETERY OR CREMATORY Johns Hopkins Hospital		24D. LOCATION (City, town, or county) (State) 601 N Broadway, Balbo., MD.	
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR Robert E. Taber, M.D.	
25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		25D. ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

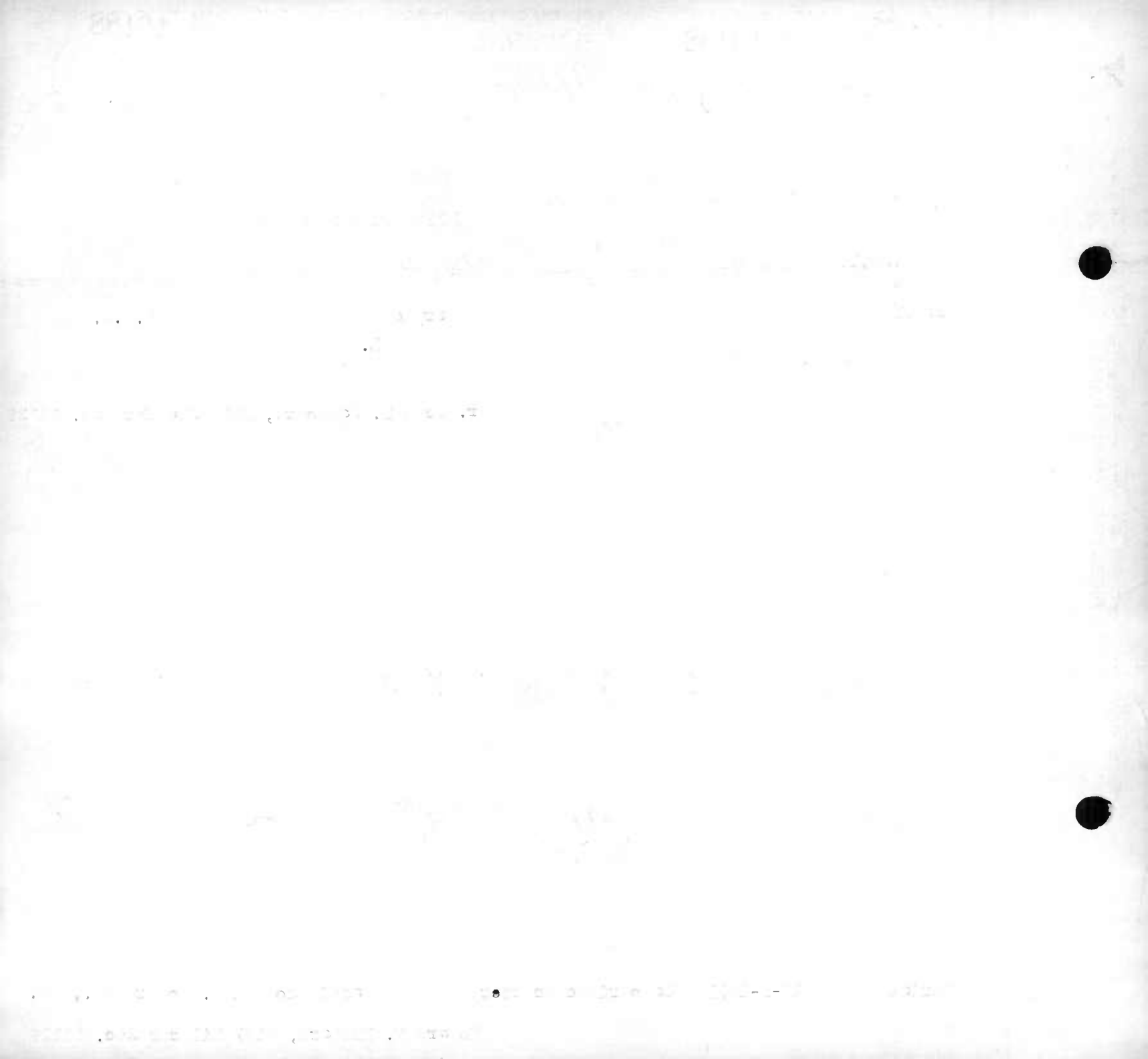
BIRTH NO. 71 10187			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
NEIGHOFF, CHARLES HENRY		NOVEMBER 2, 1971 8:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE B. COUNTY	
ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE, MD. 21229		MARYLAND Baltimore	
C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER		5543 GAYLAND ROAD 21227	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	09-17-81
9. AGE (In years last birthday)		10. UNDER 1 Yr. Months: Days	
90		11 Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
RETIRED PAINTER		SELF EMPLOYED	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MARYLAND		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
DAVID NEIGHOFF		KATHERINE (Unknown)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NO		220079865	
17. Informant		ADDRESS	
Mr. Bernard Neighoff, 5543 Gayland Rd. 21227		ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Pleural effusion, paralytic ileus	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 22</u> 19 <u>71</u> to <u>NOVEMBER 2</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>NOVEMBER 2</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
J.J. Mol.		11-2-71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
J.J. Mol.		Caton & Wilkens Ave	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	11-5-1971	Loudon Park Cemetery	Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS	
NOV 5 1971	Robert E. Taylor, M.D.	Howard H. Hubbard, 4107 Wilkens Ave. 21229	

12/7/72-NI-From JHH-Letter
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e. Edmund Pauline
Fred - Son of Richard - American Old

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10188	
CERTIFICATE OF DEATH					
R-526 BIRTH NO. 19-07308 10188					
1. NAME OF DECEASED (Type or Print) RANCOURT, LISA MARIE			2. DATE AND HOUR OF DEATH 11/3/71 1:50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2006		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3236 Stafford Street		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/21/69	9. AGE (In years last birthday) 2	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Rene P. Rancourt		14. MOTHER'S MAIDEN NAME L. Lana Shugars		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Rene P. Rancourt, 3236 Stafford St. 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH laminectomy for NEUROFIBROMATOSIS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4.3 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 310/29/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED spinal cord tumor		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/18/71 to 11/3/71 that (I) (we) last saw the deceased alive on 11/3/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leslie P. Plotnick M.D.				23B. DATE SIGNED 11/3/71	
23C. PHYSICIAN'S NAME (Type) Leslie Plotnick, M.D.				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-1971		24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery	
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	
25D. LOCATION (City, town, or county) Washington Blvd. Howard Co., Md.					



BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		71 10189	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print)		EDWARD H. COUGNET, SR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		00 345 Stinson St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 1 1971 10 a M.	
6. SEX male		7. RACE white		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2001	
8. MARried <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 10-18-1927		10. AGE (In years last birthday) 44		E. STREET AND NUMBER 345 Stinson St.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Emil C. Cougnet	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		14B. KIND OF BUSINESS OR INDUSTRY Elicpes Mattress Co.		15. MOTHER'S MAIDEN NAME Mary Hedding	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II		17. SOCIAL SECURITY NO. 219-22-7728		18. INFORMANT Mrs. Helen E. Cougnet, 34 S. Carlton St.	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11-1-71 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-1971		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25D. ADDRESS		25E. ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

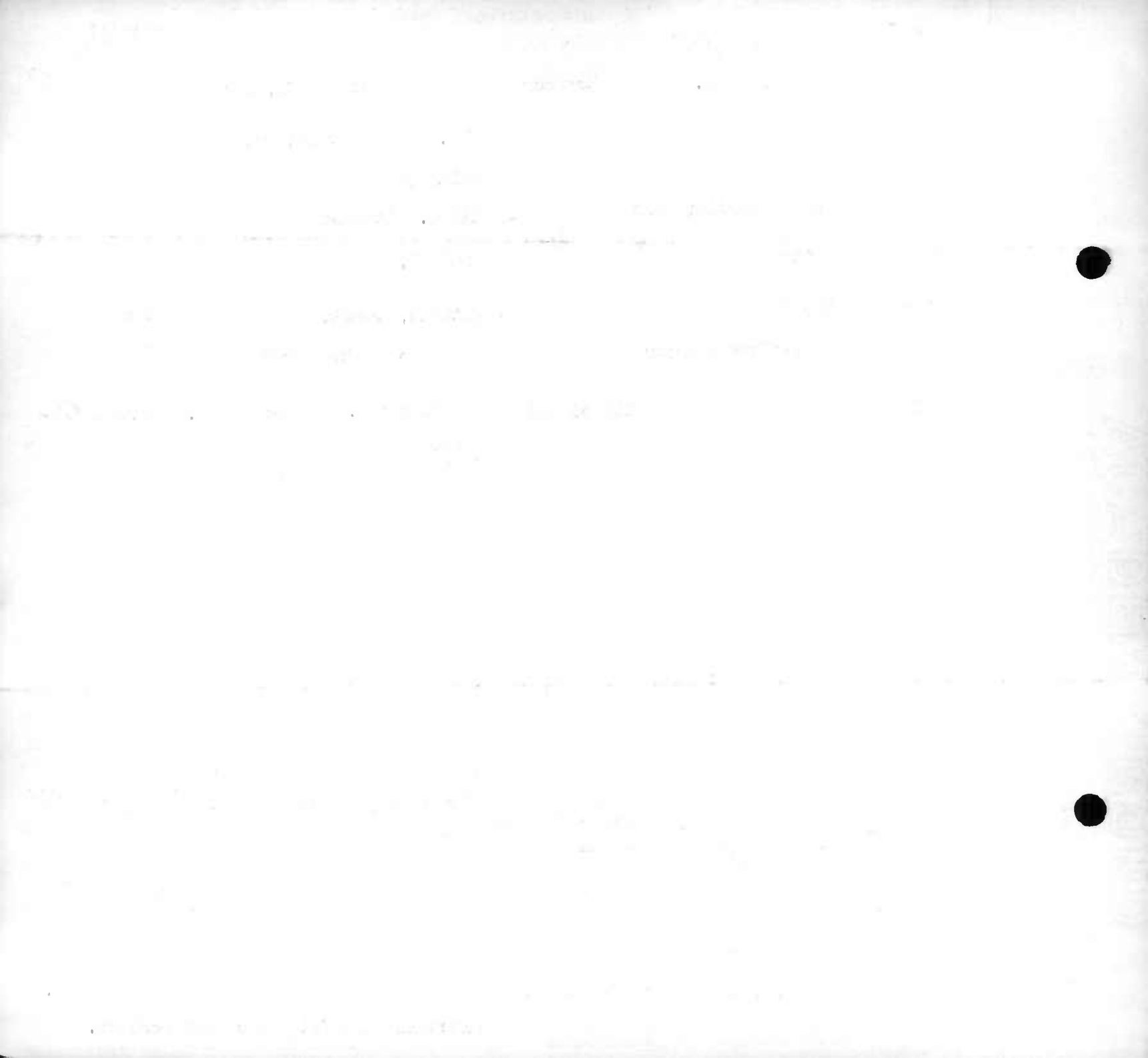
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-632 71 10190				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10190	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				PROTZ, ARTHUR F.		November 2, 1971 10:20 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland		B. COUNTY BALTIMORE	
Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				C. CITY OR TOWN Landsdown		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 151 Clyde Ave.							
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-7-97	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
XXXX Inspector		Westinghouse		Brooklyn, New York		U. S. A.	
13. FATHER'S NAME C. Frederick Protz				14. MOTHER'S MAIDEN NAME Grace Denison			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes 16 to 18				212-05-38-00		Records Iv A. Hospital 3900 Loch Raven Blvd., Baltimore, Md.	
18. 569.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Pulmonary edema - renal failure DUE TO, OR AS A CONSEQUENCE OF:			
				(C) Sepsis - perforated bowel-peritonitis			
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				48 hours			
				72 hours			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 10/31/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED peritonitis - perforated small bowel		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from October 22, 1971 to November 2, 1971, that (X) (we) last saw the deceased alive on November 2, 1971 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A. C. [Signature] DEGREE						23B. DATE SIGNED 11/3/71	
23C. PHYSICIAN'S NAME (Type) Antonio C. [Signature] DEGREE						23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11-5-1971		Loudon Park Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 5 1971		Robert E. [Signature]		Howard H. Hubbard		4107 Wilkens Ave. 21229	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 10191</u>	
S-560 BIRTH NO. <u>71 10191</u>			
1. NAME OF DECEASED (Type or Print) Glen F. Seymour		2. DATE AND HOUR OF DEATH October 31, 1971 <u>930P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Long Green Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 213 E. Gittings Ave	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1888
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Retired		9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ontario, Canada	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Theodore Seymour		14. MOTHER'S MAIDEN NAME Josephine Wood	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 216 01 8959	17. INFORMANT Mrs Mildred C. Seymour
18. 440.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) INTERCEREBRAL ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 1970</u> to <u>Oct 31 1971</u> that (I) (we) last saw the deceased alive on <u>Oct 25 1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED 11-2-71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/3/71	24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery
24D. LOCATION Woodlawn Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home	
		ADDRESS 6500 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO.	
H-632 71 10192		71 10192		71 10192	
1. NAME OF DECEASED (Type or Print) HOROWITZ, GEORGE		2. DATE AND HOUR OF DEATH 11/2/71 7:10 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSP BALTIMORE		E. STREET AND NUMBER 6800 LIBERTY ROAD, APT. 1009			
5. SEX male	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/14/1902	9. AGE (In years last birthday) 69	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Private enterprise		10B. KIND OF BUSINESS OR INDUSTRY Auto Spring		11. BIRTHPLACE (State or foreign country) NEW YORK CITY, N. Y.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GERSHON HOROWITZ			
14. MOTHER'S MAIDEN NAME LEAH ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 084-01-1755		17. INFORMANT ADDRESS BALMORAL APTS., APT. 1009 MRS. ANNE HOROWITZ, 6800 LIBERTY RD. #21207			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 569.9 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiopulmonary Arrest (B) DUE TO, OR AS A CONSEQUENCE OF: Pulmonary edema (C) SI Bleeding			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/1/71 to 11/2/71 that (I) (we) lost saw the deceased alive on 11/2/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE K. Michopoulos MD		23B. DATE SIGNED 11/2/71		23C. PHYSICIAN'S NAME (Type) K. Michopoulos MD	
23D. ADDRESS SINAI HOSP. BALTO.		23E. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-3-71		24C. NAME of CEMETERY or CREMATORY BETH TFILOH	
24D. LOCATION BALTIMORE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. NOV 5 1971			
24F. NAME OF REGISTRAR Robert E. Fisher		24G. FUNERAL DIRECTOR SOL LEVINSON & BROS.		24H. ADDRESS 6010 REISTERSTOWN ROAD	

Cardiovascular Arrest

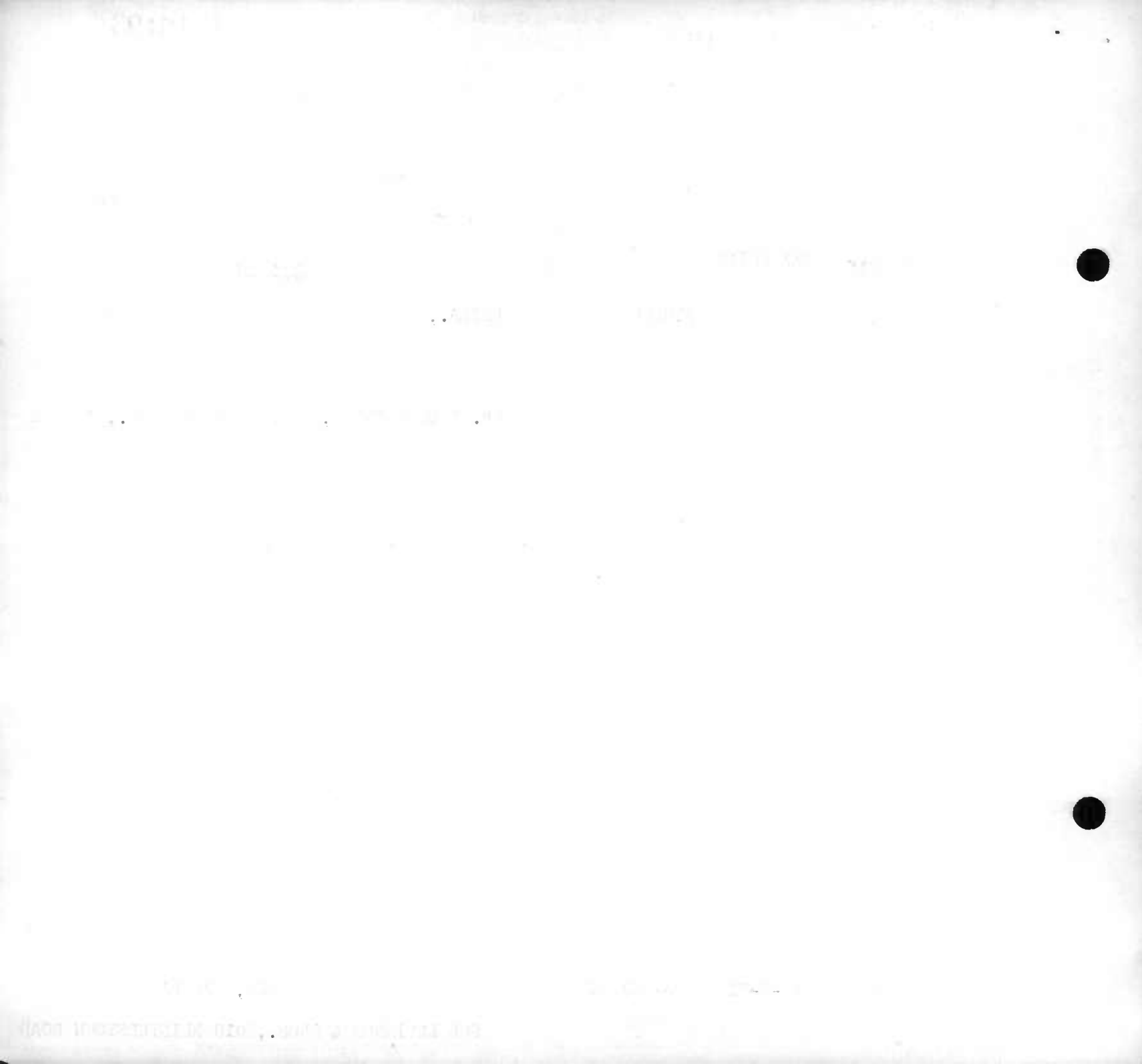
Pulmonary edema

12/11/21

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

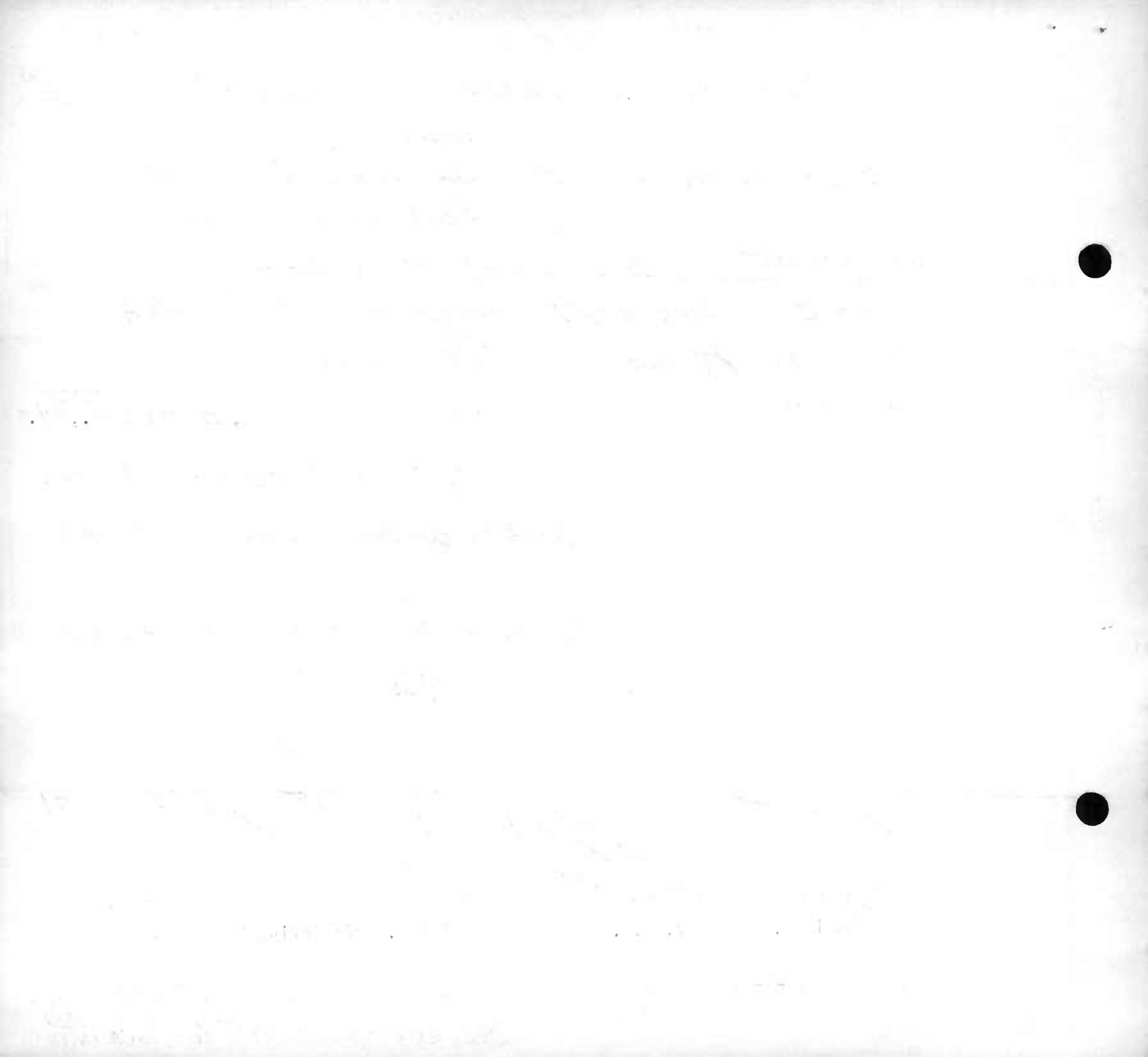
K-255 71 10193		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 10193	
1. NAME OF DECEASED (Type or Print) ADELINE KOCHMAN		2. DATE AND HOUR OF DEATH 10/31/71 350 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MD. HOSPITAL 38		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 7945 STEVENSON RD.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-07	9. AGE (in years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY ATHOME		11. BIRTHPLACE (State or foreign country) PHILA., PENNA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ALBERT SCHNEYER		14. MOTHER'S MAIDEN NAME JENNIE RUDLEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT DR. LEON KOCHMAN, 7945 STEVENSON RD., #21208	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE PULMONARY METASTASES 3 mos. (B) intraabdominal Cancer - prob pancreatic 6 mos. (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCT 25 19 71 to OCT 31 19 71 that (I) (we) last saw the deceased alive on OCT 30 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kenneth V. Eden, M.D.		23B. DATE SIGNED 10/31/71		23C. PHYSICIAN'S NAME (Type) KENNETH V. EDEN, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-3-71		24C. NAME OF CEMETERY OR CREMATORY HAR SINAI	
24D. LOCATION (City, town, or county) (State) OWINGS MILLS, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971			
25B. NAME OF REGISTRAR Robert E. Garber, R.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10194</u>	
17-220 71 10194 BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>HERBERT L. MOSES</u>		2. DATE AND HOUR OF DEATH <u>NOVEMBER 2/71</u> <u>8:30</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 3607 MENLO DRIVE</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2720</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3607 MENLO DRIVE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 11/1888</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EXECUTIVE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>MERCHANT</u>		11. BIRTHPLACE (State or foreign country) <u>CAROLINA STATESVILLE, NORTH</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ABRAHAM MOSES</u>			
14. MOTHER'S MAIDEN NAME <u>ROSE LEVY</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) <u>YES WWI</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS #21210 <u>MRS. MARGARET HECHT-23 HAMILL RD., APT. 5</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>437.91-093.9</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Aspiration pneumonia</u> (B) <u>Cerebral atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>5 yrs</u>		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Ischemic aortic regurgitation</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>40 yrs</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>19 68</u> to <u>11/2</u> 19 71 that (I) (we) last saw the deceased alive on <u>12/31/</u> 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Louis H. Schaffer, M.D.</u>		23B. DATE SIGNED <u>11/2/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Louis H. Schaffer, M.D.</u>	
23D. ADDRESS <u>222 W. Cold Spring Lane 21210</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>11-3-71</u>		24C. NAME of CEMETERY or CREMATORY <u>BALTIMORE HEBREW</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL. LEVINSON & BROS INC 600 REISTERSTOWN RD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 10195</u>	
B-625 71 10195				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Hans Bergmann</u>		2. DATE AND HOUR OF DEATH <u>October 14, 1971 103 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. (INSIDE CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Maryland Hospital</u> <u>38</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>1 East University Parkway</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-19-03</u>	9. AGE (in years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TECHNICIAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>PATHOLOGY</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>May Bergmann</u>		14. MOTHER'S MAIDEN NAME <u>Margaret A</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>NWII</u>		16. SOCIAL SECURITY NO. <u>579-36-8662</u>		17. INFORMANT <u>Hospital Face Sheet</u>	
18. <u>205.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Probable Cerebrovascular Hemorrhage</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myelomonocytic Leukemia 1 week</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>October 5 1971</u> to <u>October 14 1971</u> that (I) (we) last saw the deceased alive on <u>October 14 1971</u> and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE <u>A. Arthur Steele MD</u>				23B. DATE SIGNED <u>10/14/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. ARTHUR STEELE MD</u>		23D. ADDRESS <u>Univ. of Maryland Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>11/2/1971 CREMATION</u>		24B. DATE <u>11/2/1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>L 8000</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 5 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Dr. Arthur Steele, M.D.</u>			

16

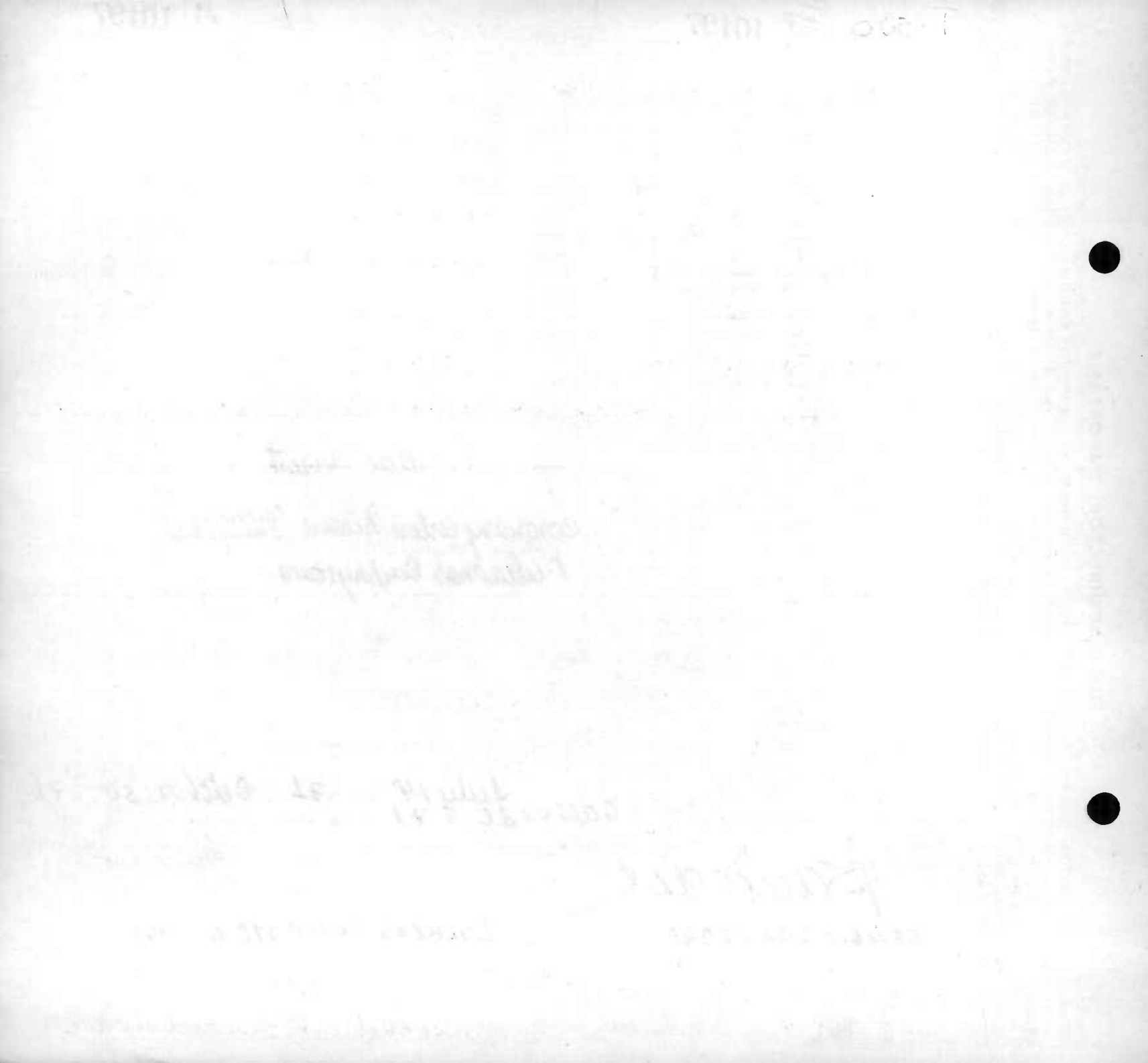
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10197	
R-500 71 10197 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) William Carl Renna		2. DATE AND HOUR OF DEATH 11/4/71 5: A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2005		
FULL NAME OF HOSPITAL OR INSTITUTION 00			(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2636 Lehman St		C. CITY OR TOWN Baltimore
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2636 Lehman St
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/28/09	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Bus Driver			11. BIRTHPLACE (State or foreign country) Baltimore Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William H. Renna			14. MOTHER'S MAIDEN NAME Theresa Quinn		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-16-1356		17. INFORMANT Mrs. Mary Renna
			ADDRESS 2636 Lehman St.		
18. 412.31			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Coronary Arteri Disease, Coronary Fissure DUE TO, OR AS A CONSEQUENCE OF: (C) Pulmonary Emphysema		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 14 1971 to October 30 1971 , that (I) (we) last saw the deceased alive on October 30 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sau Pedro				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) SERBIO SAN PEDRO				23D. ADDRESS WILKENS AND CATON AVE.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-6-71		24C. NAME of CEMETERY or CREMATORY New Cathedral Cem	
24D. LOCATION Balto City		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Acio & Relivah	
		ADDRESS 3101 Frederick Ave			



FUNERAL DIRECTOR: IMPORTANT

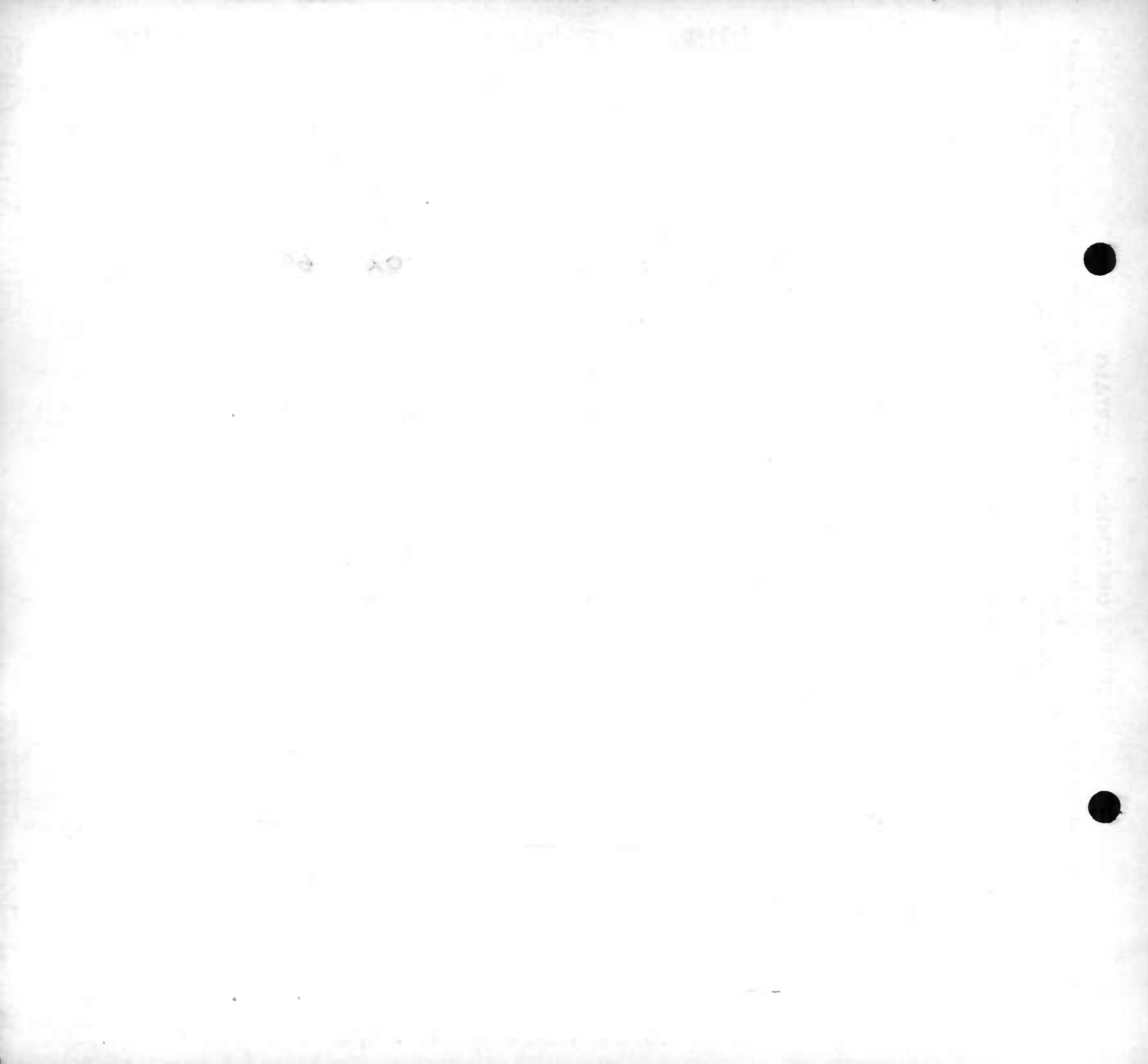
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 10198

BIRTH NO. B-655 71 10198		2. DATE AND HOUR OF DEATH November 1 1971 12³⁰ A.M.	
1. NAME OF DECEASED (Type or Print) Hattie E Ha Burbannan (Foote)		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 1203	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Union Memorial Hospital 44		E. STREET AND NUMBER 2418 N Calvert St	
5. SEX Fe	6. RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05-18-02 9. AGE (in years lost birthday) 69 yro
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Ruth Johnson 2418 N. Calvert Street ADDRESS	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebro Vascular Accident DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerosis Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF: (C) CHF - Atrial Fibrillation - Dehydration	
19. DATE OF OPERATION		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/> No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from 10-29 19 71 to 11-1 19 71 that (I) last saw the deceased alive on 11-1 19 71 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.		21F. HOW DID INJURY OCCUR?	
23A. SIGNATURE Julio A. Dejo		23B. DATE SIGNED 11-1-71	
23C. PHYSICIAN'S NAME (Type) Julio A. Dejo M.D.		23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-5-71	24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery	24D. LOCATION (City, town, or county) (State) Balto., Md.
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971	25B. NAME OF REGISTRAR Julio A. Dejo	25C. FUNERAL DIRECTOR Wm C March 928 E North Ave. ADDRESS	



BALTIMORE CITY HEALTH DEPARTMENT				71 10199	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 71 10199	
BIRTH NO. _____					
1. NAME OF DECEASED (Type or Print) GEORGE E. WHITMIRE			2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month November Day 3 Year 1971 Hour _____ M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2440 Robb Street			3. DATE PRONOUNCED DEAD Month November Day 3 Year 1971 Hour 11:00 A. M.		
6. SEX Male			7. RACE Negro		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN Baltimore		
9. DATE OF BIRTH 11-28-14			10. AGE (In years last birthday) 56		
11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? Frank Whitmire		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker			15. MOTHER'S MAIDEN NAME Lydia Roberts		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII			17. SOCIAL SECURITY NO. 242-05-8964		
18. INFORMANT Mrs. Gertie M. Whitmire			ADDRESS 2040 Robb St		
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 162.1 I CAUSE OF DEATH A (A) IMMEDIATE CAUSE Carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20A. DATE OF OPERATION 0			20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22F. HOW DID INJURY OCCUR?			21. AUTOPSY? (Yes or No) No		
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 4, 1971		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-8-71		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem Park	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm C March			
25D. ADDRESS 928 E North Ave.					

IN SENATE
January 10, 1910

REPORT OF THE

COMMISSIONER OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

ON JANUARY 1, 1909

ALBANY:

THE UNIVERSITY OF THE STATE OF NEW YORK

1910

PRINTED BY THE UNIVERSITY OF THE STATE OF NEW YORK

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 10200

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Everett (Edward) Boone		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 11 2 71 4:31 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2102 Barclay St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 2 71 4:31 p. M.	
6. SEX male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 12-23-23		10. AGE (In years last birthday) 47	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 429-14-2540	
18. INFORMANT Rev Arthur Boone		ADDRESS 2000 Homewood St	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/3/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-6-71	
24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E North Ave.	

VS 151-REV. 1/1/68

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W-460 71 10201

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 10201

BIRTH NO. 71-13542

1. NAME OF DECEASED (Type or Print) WILLIAM A. WHEELER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 3, 1971 5:25 A.M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 901	
7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 8-8-71	10. AGE (In years lost birthday) 2 23	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Maryland		E. STREET AND NUMBER 621 Cator Avenue	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME William F. Wheeler II	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Riva Youmans	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Nina Youmans		ADDRESS 627 Cator Ave.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 931.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Pneumonia and Hyaline Membrane Disease complicating overdose of Chloramphenicol and (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Salmonella infection		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 11-6-71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital	
22C. WHERE DID INJURY OCCUR? Johns Hopkins		22D. HOW DID INJURY OCCUR? Therapeutic Misadventure	
22E. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) Nov. 1971 ? m.		22F. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/3/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-6-71	24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery	24D. LOCATION (City, town, or county) (State) Balto., Md.
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971	25B. NAME OF REGISTRAR Ronald N. Kornblum, M.D.	25C. FUNERAL DIRECTOR ADDRESS Wm C March 928 E. North Ave.	

VS 151-REV. 1/1/68

N 9009210304192

Letter from M.E.'s office

12-8-71

M.H.

Handwritten signature

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E-363 71 10202

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10202

BIRTH NO.

1. NAME OF DECEASED (Type or Print) O'Neil Edwards		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 11 2 71 6:37 p. m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 2 71 6:37 p. m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 906	
9. DATE OF BIRTH 10-21-07		10. AGE (In years last birthday) 64	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? Unknown	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 14B. KIND OF BUSINESS OR INDUSTRY Davison Chemical		15. MOTHER'S MAIDEN NAME Unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 239-05-4786	
18. INFORMANT Mr James Edwards		ADDRESS 1728 Bradford St.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) yes	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/3/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-6-71	
24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E North Ave.	

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FUNERAL DIRECTOR: IMPORTANT

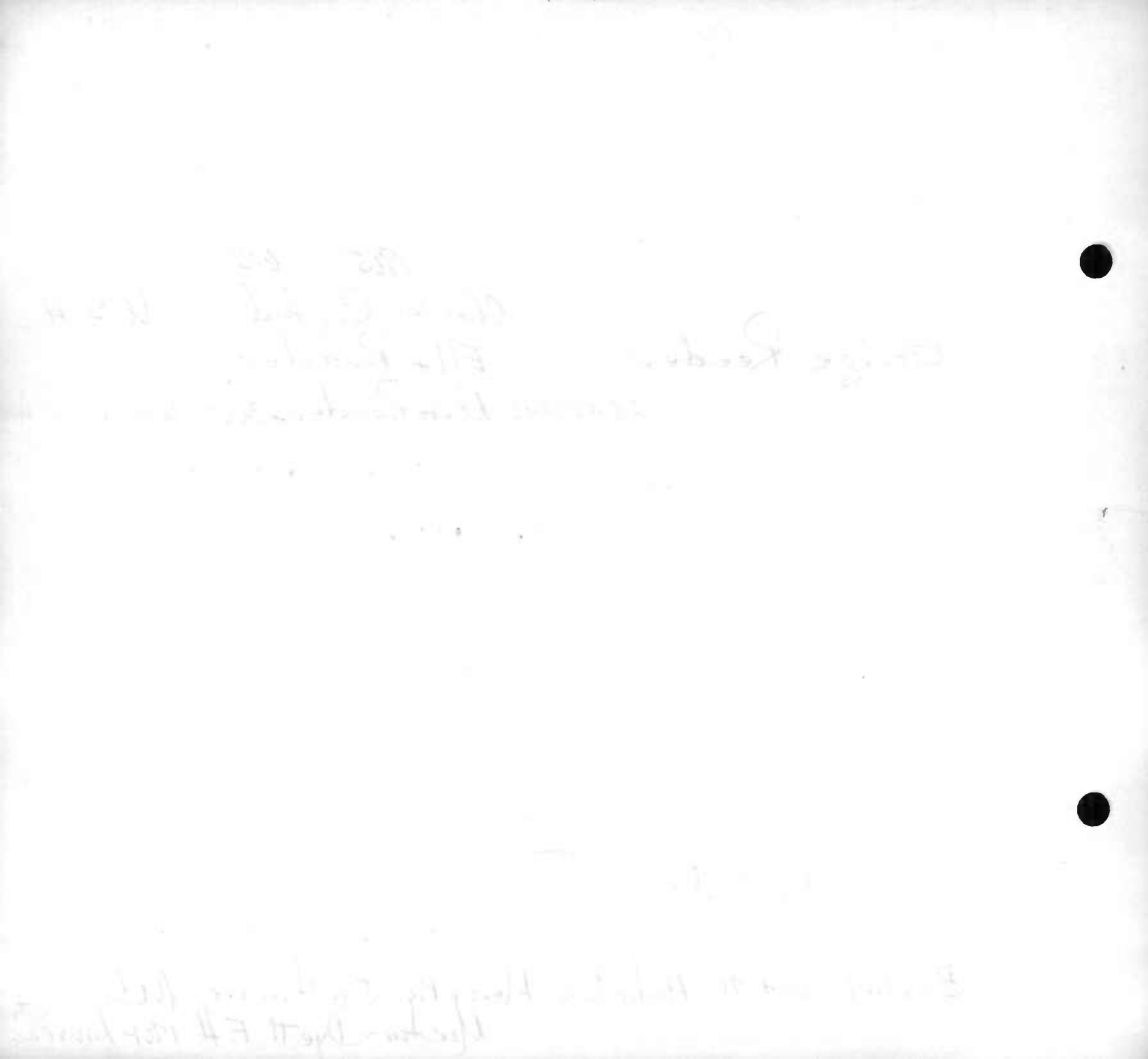
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 10203</u>	
R-263 <u>71 10203</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>RICHARDSON, CHRISTINE</u>		2. DATE AND HOUR OF DEATH <u>11/2/71</u> <u>4:00 am.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2506</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3330 Fairfield Road.</u>			
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-11-34</u>	9. AGE (In years last birthday) <u>37</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>N.C. Johnston C.</u>	
13. FATHER'S NAME <u>Herbert Harrington</u>		14. MOTHER'S MAIDEN NAME <u>Lida Harrington</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>246-16-2657</u>		17. INFORMANT <u>R. Siritthara. M.D. South Baltimore General</u>	
18. <u>430.7 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Subarachnoid hemorrhage probably</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Subarachnoid hemorrhage probably</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Resp</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>-</u>		(C) DUE TO, OR AS A CONSEQUENCE OF: <u>-</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>-</u>					
19A. DATE OF OPERATION <u>2 w</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>w</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>-</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I certify that (4) (this hospital) attended the deceased from <u>11/1/71</u> to <u>11/2/71</u> that (I) (we) last saw the deceased alive on <u>11/2/71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. Siritthara.</u>				23B. DATE SIGNED <u>11/2/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>SIRITHARA</u>				23D. ADDRESS <u>M.D. South Baltimore General Hospital.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-5-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery Baltimore, Md</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Barber, M.D.</u>	
		25C. FUNERAL DIRECTOR <u>Morton Dye</u>		25D. ADDRESS <u>F. H. 1701 - Havens St</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		71 10204		71 10204	
BIRTH NO. <u>R-360</u>		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Scuse Reeder</u>			2. DATE AND HOUR OF DEATH <u>10-31-71</u> <u>802</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Luthuan Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1506</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3005 Walbrook Ave.</u>		
5. SEX <u>Male</u>	6. RACE <u>B</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-1905</u>	9. AGE (in years last birthday) <u>65</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		
11. BIRTHPLACE (State or foreign country) <u>Charles Co, Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George Reeder</u>			14. MOTHER'S MAIDEN NAME <u>Ellie Reeder</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>			16. SOCIAL SECURITY NO. <u>218-05-9543</u>		17. INFORMANT <u>Nova Reeder</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>43701</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>CEREBRAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>24 hrs.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>HYPERTENSION</u> DUE TO, OR AS A CONSEQUENCE OF: <u>—</u> (c) <u>—</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>		
19A. DATE OF OPERATION <u>10/28/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>No?</u>		20A. AUTOPSY? (Yes or No) <u>No?</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>10/28/71</u> to <u>10/31/71</u> that (I) (we) last saw the deceased alive on <u>10/31/71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Geoffrey</u>			23B. DATE SIGNED <u>10/31/71</u>		23C. PHYSICIAN'S NAME (Type) <u>AZAD CADER MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>11-4-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memory Park</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>			25A. DATE REC'D BY HEALTH DEPT. <u>NOV 5 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>			25C. FUNERAL DIRECTOR <u>Monetom Dye H. F. H. 1701 Laurens St.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10205	
2-200 71 10205		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Leak, Rudolph O.</i>		2. DATE AND HOUR OF DEATH <i>11/4/71 3:30 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2004</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>46 Lutheran Hosp. of Maryland</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i>		6. RACE <i>N N</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Porter</i>		8. DATE OF BIRTH <i>9-5-16</i>	
13. FATHER'S NAME <i>Oscar Leak</i>		14. MOTHER'S MAIDEN NAME <i>Francis Terry</i>		9. AGE (in years last birthday) <i>55</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>1942 Dec 1945</i>		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <i>Nor. Car. Hamlett</i>	
17. INFORMANT <i>Mozelle Leak</i>		ADDRESS <i>2575-W. Balt. St</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
18. <i>73619 I</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>C V A</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX) 1(Month) 1(Day) (Year) 1(Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/2</i> 19 <i>71</i> to <i>11/4</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>11/4</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Young Souk Kim, M.D.</i>		23B. DATE SIGNED <i>11/4/71</i>			
23C. PHYSICIAN'S NAME (Type) <i>Young Souk Kim, M.D.</i>		23D. ADDRESS <i>Lutheran Hosp. of Maryland</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-8-71</i>		24C. NAME of CEMETERY or CREMATORY <i>Western Star</i>	
24D. LOCATION <i>Baltimore, Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>NOV 5 1971</i>		24F. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
24G. FUNERAL DIRECTOR <i>Morton Dyett F.H.</i>		24H. ADDRESS <i>1701-LANVENE</i>			

Postcard

From Jack
and the wife

London

January 10 - 4

High the bank across the river

Printed and Published by
Messrs. W. & A. Gifford

B-260 71 10206				BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 71 10206			
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) ARTHUR BOWSER				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 MERCY HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year Hour November 3, 1971 1:15 A. M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Sept., 1, 1940				10. AGE (In years last birthday) 30		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 302	
11. BIRTHPLACE (State or foreign country) Roanoke Rapids, N. C.				12. CITIZEN OF U. S. A.		C. CITY OR TOWN Baltimore	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C				14B. KIND OF BUSINESS OR INDUSTRY Unemployed		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO.		E. STREET AND NUMBER 1029 E. Baltimore Street	
18. INFORMANT Mary Martin				ADDRESS 335 Harlem Avenue			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 571,814-011.9 Fatty metamorphosis of liver				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II Pulmonary tuberculosis				(B) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21. AUTOPSY? (Yes or No) yes (Partial)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?				23.			
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 11/3/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-7-71		24C. NAME OF CEMETERY or CREMATORY Springfield Cemetery		24D. LOCATION (City, town, or county) (State) Littleton, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Morton & Dyett F. H.		ADDRESS 1701 Laurens St.	

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John Brown

John Brown

John Brown

John Brown

John Brown

John Brown

John Brown

John Brown

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10207</u>	
BIRTH NO. <u>M-250 71 10207</u>					
1. NAME OF DECEASED (Type or Print) <u>MOUZON, Bessie</u>		2. DATE AND HOUR OF DEATH <u>10/31/71</u> <u>2¹⁵</u> <u>A. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>909</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>B</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>2-15-28</u>		9. AGE (In years last birthday) <u>43</u>		10. UNDER 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>KSAU, Redd</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Thornton</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Thomas Mouzon-1313 - Greenmount Ave.</u>	
18. <u>4310 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>Hypertension</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Hemorrhage</u> (B) <u>Hypertension</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 29</u> 19 <u>71</u> to <u>Oct 31</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Oct. 31</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stephen B. Baylin</u> M.D. DEGREE				23B. DATE SIGNED <u>10/31/71</u>	
23C. PHYSICIAN'S NAME (Typed) <u>STEPHEN B. BAYLIN M.D.</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-4-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Baker Cemetery Baltimore, Md.</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		24E. (State) <u>Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 5 1971</u>	
25B. NAME OF REGISTRAR <u>Robert E. H. H. H.</u>		25C. FUNERAL DIRECTOR <u>Morton D. Dett E. H. 1701 - LAUREL</u>		25D. ADDRESS <u>1701 - LAUREL</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

8-152 71 10208		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10208	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) SPENCER ARTHUR C.		2. DATE AND HOUR OF DEATH 11/2/71 11 15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY 704		5. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital 33		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 943 N. Castle	
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04/09/85	9. AGE (In years last birthday) 86	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabin Operator		10B. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) Charlottesville Co. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME David Spencer		14. MOTHER'S MAIDEN NAME Diley Morton	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 40-0488		17. INFORMANT Mattie Spencer 1433 Mulliken Ct.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease or complication which caused death.) 2° Burns		IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2/5		19B. CONDITION FOR OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 943 N. Castle St 704	
21D. TIME OF INJURY (APPROX.) 11-1-71 8pm		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? PT - Balbyr Scaled	
22. I certify that (I) (this hospital) attended the deceased from 11/1 19 71 to 11/2 19 71 that (I) (we) last saw the deceased alive on 11/2 19 71 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Arthur Ostrowitz MD		23B. DATE SIGNED 11/2/71		23C. PHYSICIAN'S NAME (Type) Arthur Ostrowitz MD	
23D. ADDRESS 550 W. Broadway		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-71	
24C. NAME OF CEMETERY OR CREMATORY Not. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971	
25B. NAME OF REGISTRAR James E. Taylor, M.D.		25C. FUNERAL DIRECTOR Randolph J. Collick		25D. ADDRESS 2431 E. Oliver St.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 10209</u>	
J-520 71 10209							
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) <u>HAYES JONES</u>				2. DATE AND HOUR OF DEATH <u>11-2-71</u> <u>4 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SOUTH BALTIMORE GENERAL</u> <u>43 HOSPITAL</u>				A. STATE <u>Md.</u>		B. COUNTY <u>2562</u>	
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2538 Joseph Avenue.</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-10-01</u>		9. AGE (In years last birthday) <u>70</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Jones</u>				14. MOTHER'S MAIDEN NAME <u>Edmonia Epps</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-07-9492</u>		17. INFORMANT ADDRESS <u>Mrs. Arsenia Blackwell-2538 Joseph Ave.</u>			
18. <u>4369 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>BRONCHO PNEUMONIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>C.V.A., Right Hemiparesis & Aphasia</u> <u>old left Hemiparesis</u> <u>As C.V. H-D.</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <u>10 / 11 / 71</u> to <u>11 / 2 / 71</u> that (I) (we) lost saw the deceased alive on <u>11 / 2 / 19 71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>R. Sirithara</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11 / 2 / 71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Sirithara</u>				23D. ADDRESS <u>M.D. South Baltimore General Hosp. 3001 S. Hampton Rd. Balto. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-8-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 5 1971</u>		25B. NAME OF REGISTRAR <u>Valerie E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Mary-Elizabeth Law</u>		ADDRESS <u>802 Madison Avenue</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10210	
M-625 71 10210				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Lelia B. Morgan		415 A.M. Nov. 3, 1971 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00			A. STATE MD.		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1701 Madison Ave. Baltimore MD.			B. COUNTY 1402		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1701 Madison Ave.		
5. SEX F	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-4-1895	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Winston Salem, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-36-1305		17. INFORMANT Mrs. Margaret Brown-1701 Madison Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.21 Acute Bronchitis Consecutive Heart Failure			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			(B) HASCD DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 28 1971 to Nov 3 1971 , that (I) (we) last saw the deceased alive on Oct 28 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Benigno R. Lazaro				23B. DATE SIGNED 11-4-71	
23C. PHYSICIAN'S NAME (Type) Dr. Benigno R. Lazaro				23D. ADDRESS 1836 Edmondson Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-6-71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Mary-E Law 802 Madison Ave.	

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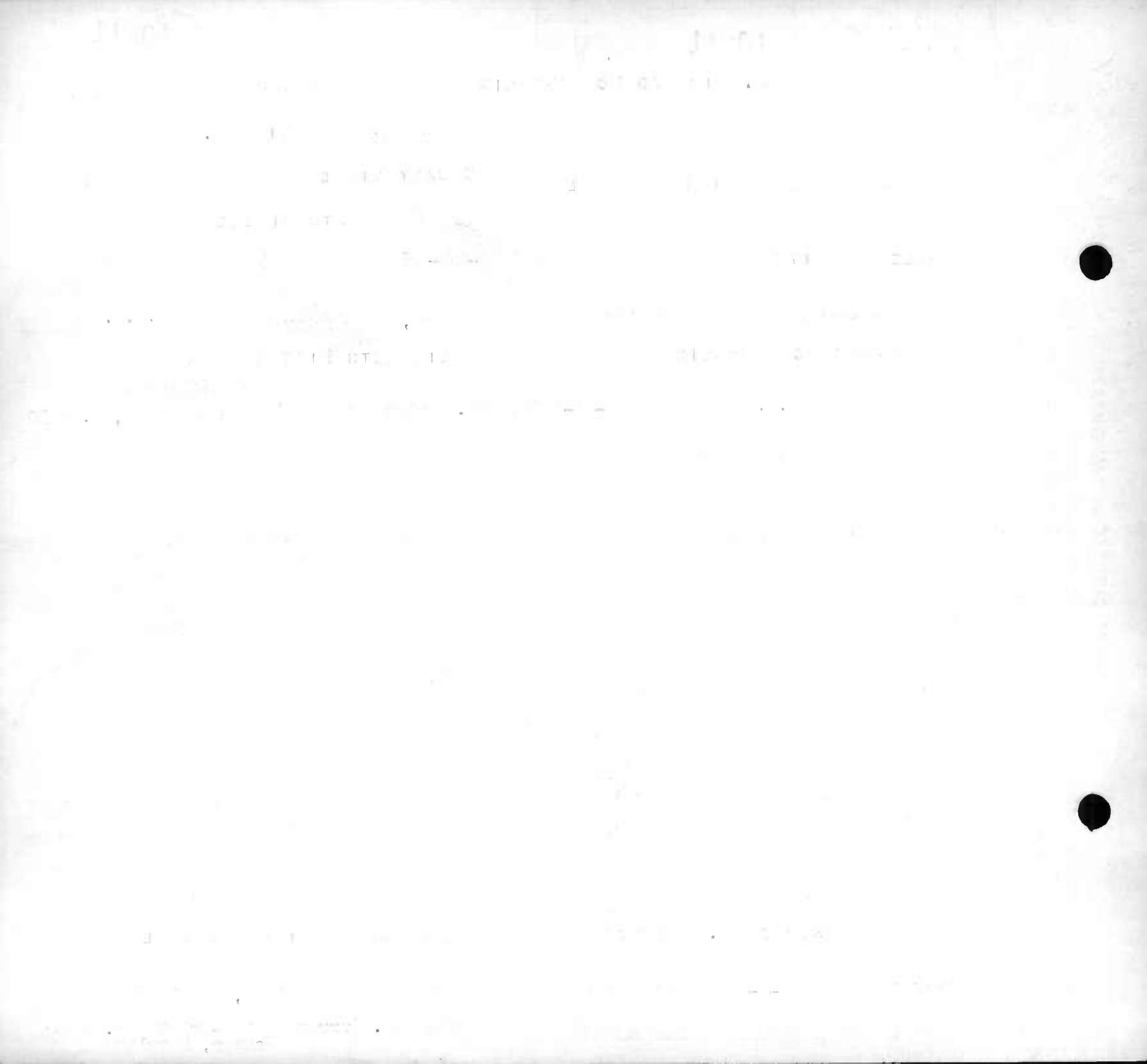
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McLaughlin, J. Richard
133 99 67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 21 10211	
BIRTH NO. M-242 71 10211		1. NAME OF DECEASED (Type or Print) J. RICHARD MC LAUGHLIN		2. DATE AND HOUR OF DEATH 11-2-71 3:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL 33				A. STATE MARYLAND B. COUNTY BALTIMORE. 5300			
				C. CITY OR TOWN COCKEYSVILLE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 10 F HOGARTH CIRCLE			
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-24-19	
				9. AGE (in years last birthday) 52		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank Executive				10B. KIND OF BUSINESS OR INDUSTRY Banking		11. BIRTHPLACE (State or foreign country) Newark, New Jersey	
13. FATHER'S NAME JAMES MC LAUGHLIN				14. MOTHER'S MAIDEN NAME ELIZABETH PISTOR		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. II				16. SOCIAL SECURITY NO. 130-09-4822		17. INFORMANT Mrs. Evelyn McLaughlin 10 Hogarth Circle Cockeysville, Md. 21030 ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hodgkins disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from Nov. 1, 1971 to Nov. 2, 1971 that (1) (we) last saw the deceased alive on Nov 2, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Thomas K. Hodous, M.D.				23B. DATE SIGNED 11/2/71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) THOMAS K. HODOUS				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-6-71		24C. NAME of CEMETERY or CREMATORY Dulaney Valley Cemetery		24D. LOCATION (City, town, or county) (State) Cockeysville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Raymond J. Curran		ADDRESS 817 Scarlett Dr. Towson, Maryland 21204	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EMERY BROOKS (Emory)

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 2540 Boyd St.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

11

1

1971

6:40a

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Md.

2004

6. SEX

male

7. RACE

negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Borne 6/19/20

10. AGE (In years
lost birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2540 Boyd St.

11. BIRTHPLACE (State or foreign country)

Balto Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Edward Brooks

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Workman

15. MOTHER'S MAIDEN NAME

Eleanor Maithen

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

17. SOCIAL
SECURITY NO.

18. INFORMANT

Mable Coleman

ADDRESS

Same

19. 412.21

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Hypertensive cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Cirrhosis of liver

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-1-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

11-4-71

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn

24D. LOCATION (City, town, or county)

BALTO. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 5 1971

25B. NAME OF REGISTRAR

Robert E. Fisher, R.D.

25C. FUNERAL DIRECTOR

E.O. Wilson

ADDRESS

1000 BRANTLEY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 10213</u>	
71 10213				71 10213	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Leake, Edley		11/3/71 8:15 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION George Washington Nurs. Home 90607 Pennsylvania Ave Baltimore, Maryland 21201			A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1215 W. Franklin Street		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/91	9. AGE (In years last birthday) 80 yrs.	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Loomberg, So. Va.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Jack Fowlkes		14. MOTHER'S MAIDEN NAME Mollie	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 142-00-7966A		17. INFORMANT Chart	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC HEART DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION last) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 18 MAY 19 69 to 3 NOV 19 71		that (1) (we) lost saw the deceased alive on 26 OCT 19 71		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Dr. Richard F. Tyson MD.			23B. DATE SIGNED NOV 3-71		23C. PHYSICIAN'S NAME (Type) Dr. Richard F. Tyson
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 11-6-71		24C. NAME of CEMETERY or CREMATORY Arboretus Mem. Park
24D. LOCATION Laurel			24E. NAME of REGISTRAR Robert E. Taylor, M.D.		24F. FUNERAL DIRECTOR Charles E. Wilson
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS 1100 Brantley Ave

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FUNERAL DIRECTOR: IMPORTANT

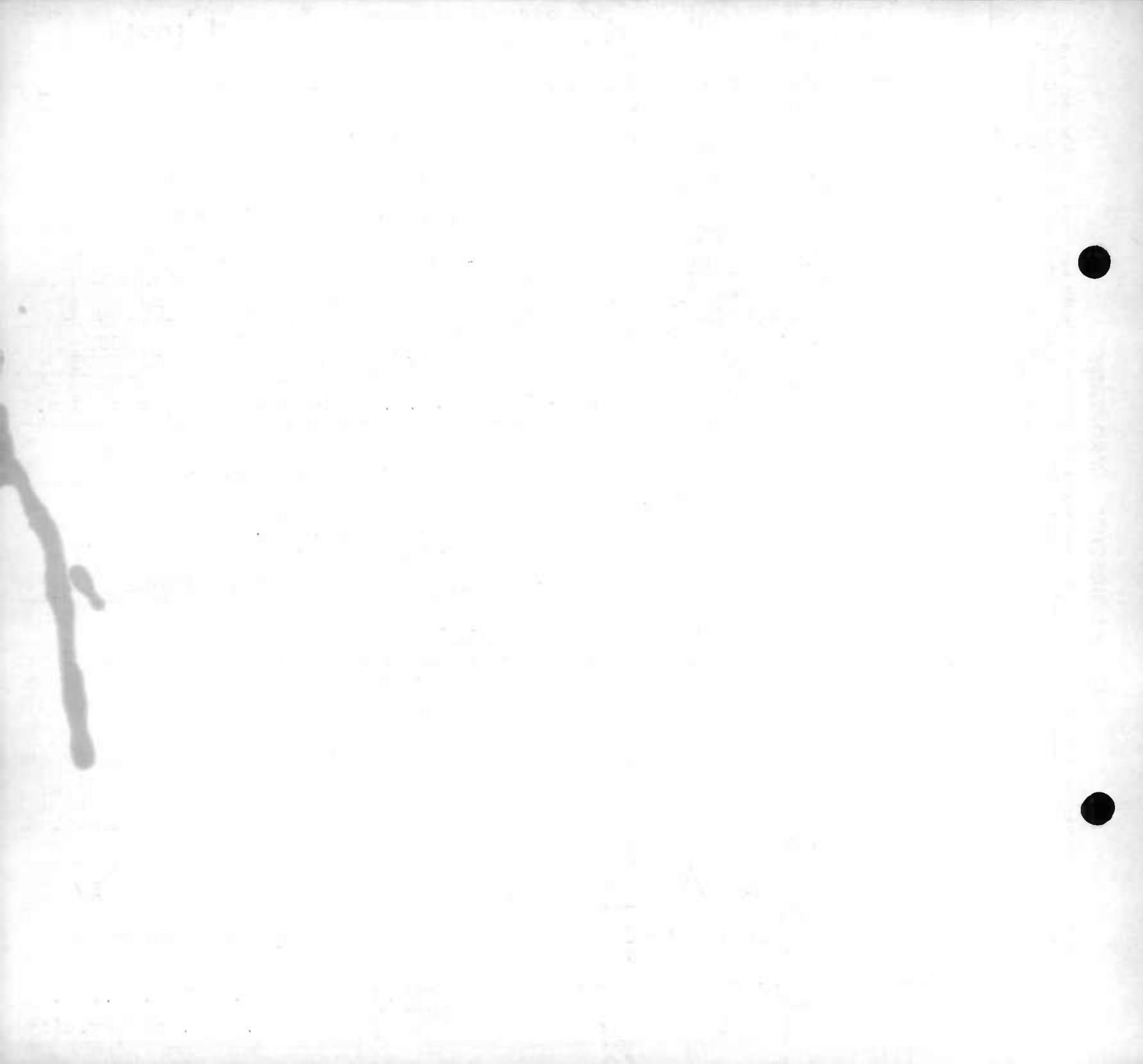
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 10214		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 10214	
BIRTH NO.		BARBARA		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DOROTHY PARKINSON				2. DATE AND HOUR OF DEATH 10/30/1971 at 1:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Montebello State Hospital				A. STATE Md.		B. COUNTY Baltimore	
				C. CITY OR TOWN Towson, Md.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female				6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10B. KIND OF BUSINESS OR INDUSTRY RETAIL SALES		8. DATE OF BIRTH 5/27/1917	
13. FATHER'S NAME Albert F. Goetze				14. MOTHER'S MAIDEN NAME ROSE HORN		9. AGE (in years last birthday) 54	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-03-5485		11. BIRTHPLACE (State or foreign country) Maryland (Baltimore)	
18. 340X1				17. INFORMANT Husband: C.J. Parkinson		12. CITIZEN OF WHAT COUNTRY? USA	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) synthetic shock				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Multiple Sclerosis				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 10/30/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/20/70 to 10/30/71 that (I) (we) last saw the deceased alive on 10/30/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Daniel A. Hanna, M.D.				23B. DATE SIGNED 10/30/1971		23C. PHYSICIAN'S NAME (Type) DANIEL A. HANNA, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/2/71		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Taylor Ave., Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR STEWART & MOWEN CO.		ADDRESS 108 W. North Ave (1)	

XXXXXX

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

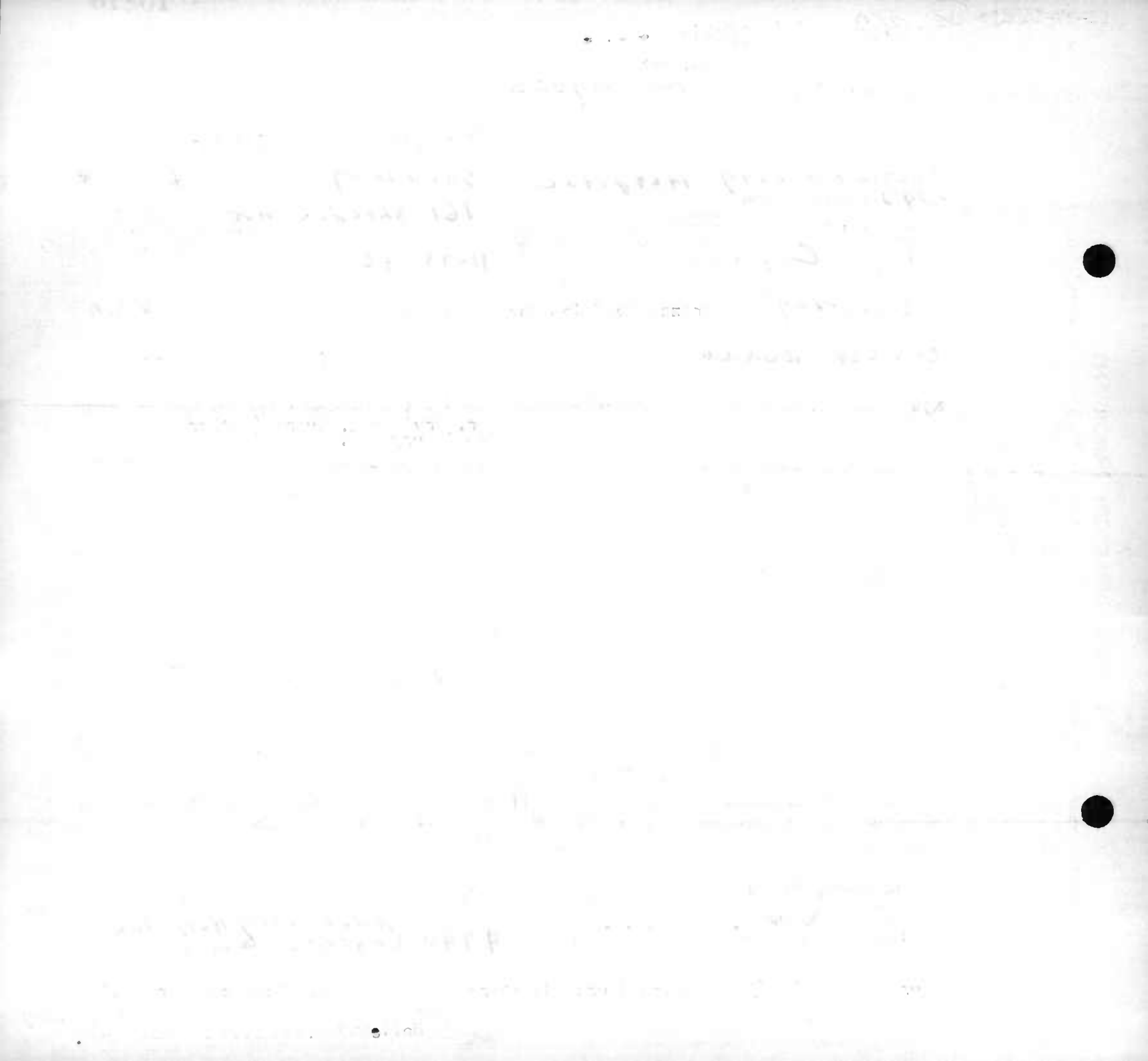
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10215	
BIRTH NO. 71 10215		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GRACE ARINTON MORGAN			2. DATE AND HOUR OF DEATH 11-2-1971 11-4 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 THE UNION MEMORIAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1201 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 116 W. UNIVERSITY PKWY		
5. SEX female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-12-95	9. AGE (in years last birthday) 76	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Painter/Realtor		11. BIRTHPLACE (State or foreign country) GEORGIA (Augusta)	
12. CITIZEN OF WHAT COUNTRY? E.E.U.U.		13. FATHER'S NAME EDWARD HENKELL BUTT UNKNOWN		14. MOTHER'S MAIDEN NAME SAVANNAH GLASCOCK BARRETT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-18-3399		17. INFORMANT: Daughter Mrs. J.M. Meyer, Green Pond, South Car.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CARDIOGENIC SHOCK ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). MYOCARDIAL INFARCTION ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION NO		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose Paz			23B. DATE SIGNED 11-2-71		23C. PHYSICIAN'S NAME (Type) JOSE PAZ
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 11/5/71		24C. NAME of CEMETERY or CREMATORY BALTIMORE NATIONAL CEM.
24D. LOCATION (City, town, or county) (State) Catonsville, Balto. Co., Md.			25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		
25B. NAME OF REGISTRAR Walter C. Taylor, M.D.			25C. FUNERAL DIRECTOR STEWART & MOWEN CO.		
25D. ADDRESS 108 W. North Av. City					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

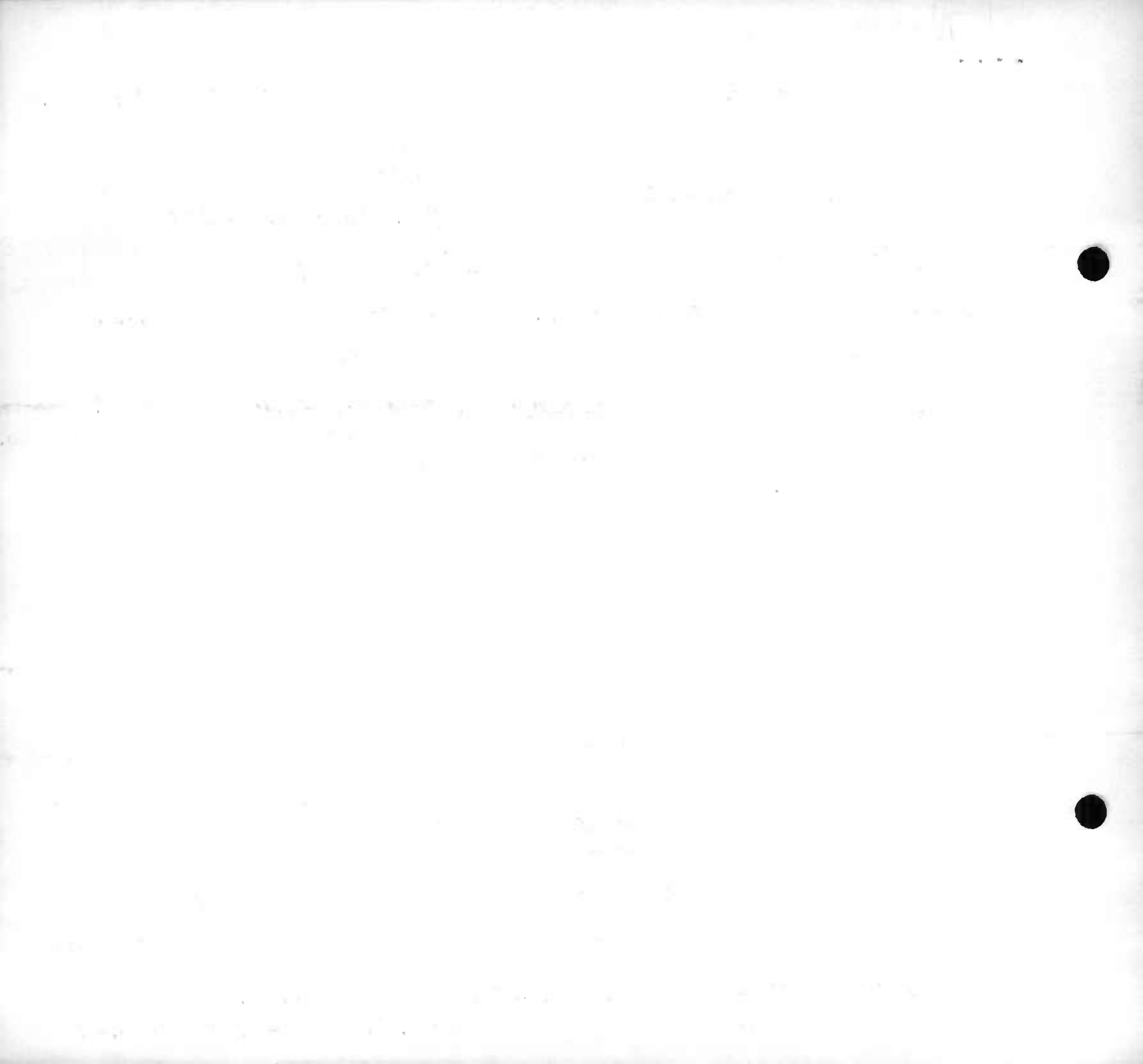
BIRTH NO. <u>K-362</u>		BALTIMORE CITY HEALTH DEPARTMENT		71 10216		X		10216	
1. NAME OF DECEASED (Type or Print) <u>Annette NATALIE Rodriguez</u>				2. DATE AND HOUR OF DEATH <u>1 NOV 71</u> <u>5³⁰</u> <u>AM.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY HOSPITAL</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>Wicomico</u> <u>7200</u>			
				C. CITY OR TOWN <u>SALISBURY</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <u>161 Sheldon Ave</u>		<u>21801</u>			
5. SEX <u>F</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-46</u>		9. AGE (In years last birthday) <u>24</u>		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Frozen Food Company</u>			11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>ORVILLE RUARK</u>				14. MOTHER'S MAIDEN NAME <u>Rose Aimee Roy</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>563-68-7981</u>		17. INFORMANT <u>BCH: RECORDS</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>2050 I</u> <u>CAUSE OF DEATH</u> <u>Mr. Orville L. Ruark (Father)</u> <u>Salisbury, Md.</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myelomonocytic Leukemia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Hepatitis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>13 months</u>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u> <u>Hepatitis</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>11 OCT</u> 19 <u>71</u> to <u>1 NOV</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>1 NOV</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Harvey M. Golomb</u> M.D. DEGREE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1 NOV 71</u>			
23C. PHYSICIAN'S NAME (Type) <u>Harvey M. Golomb M.D.</u> DEGREE				23D. ADDRESS <u>BALT. CITY HOSPITAL</u> <u>4940 Eastern Ave</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/4/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Allen Church Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Allen, Wicomico, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Hollyway</u>		ADDRESS: <u>Funeral Home</u> <u>Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

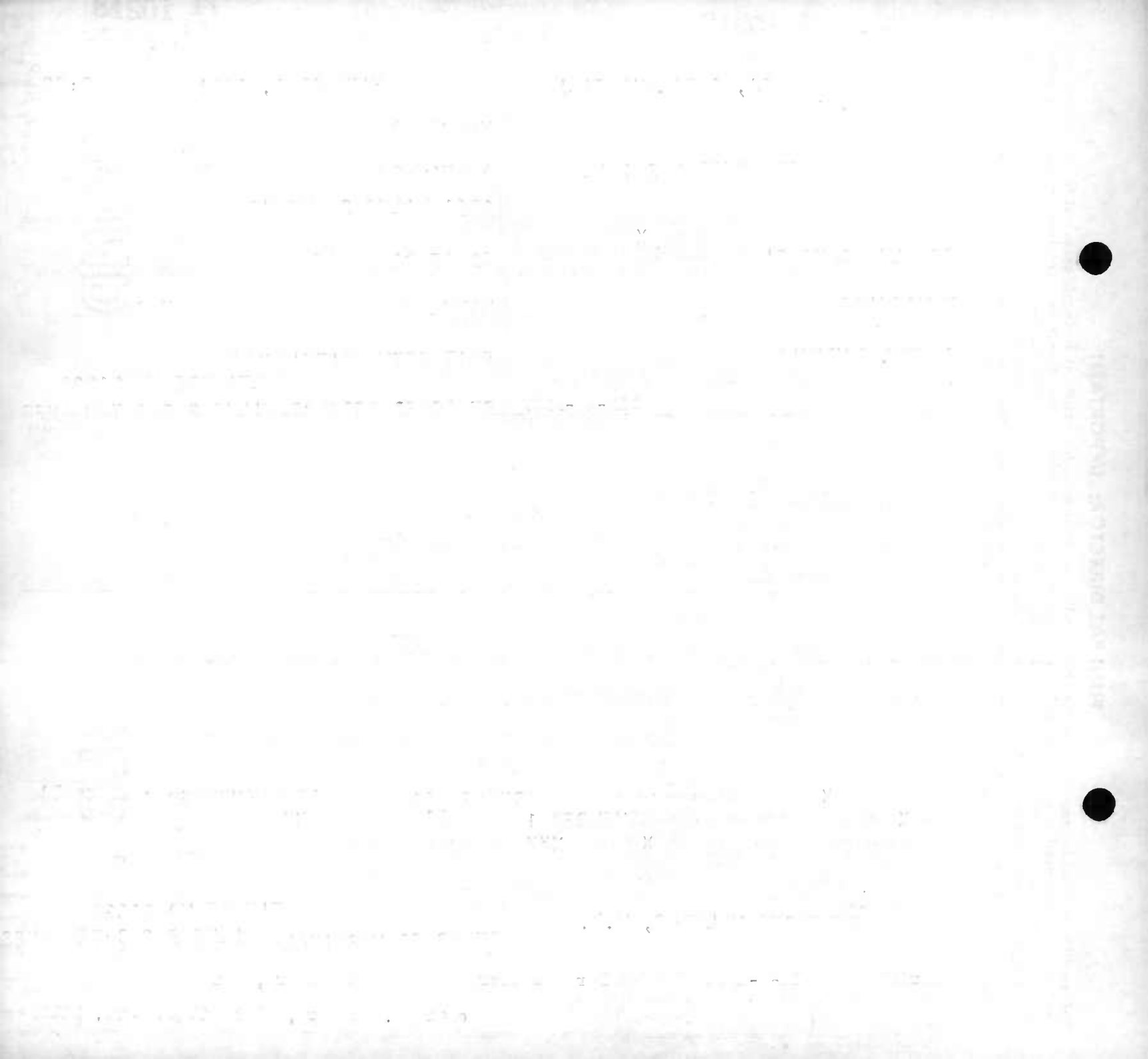
BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 10217	
BIRTH NO. N-240 71 10217					
1. NAME OF DECEASED (Type or Print) Anne E. Nickel		2. DATE AND HOUR OF DEATH November 1, 1971 12:23 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 1102 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 58 W. Biddle Street -21201			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-10	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker		10B. KIND OF BUSINESS OR INDUSTRY Finkelstein Apts.		11. BIRTHPLACE (State or foreign country) Austria	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 207-22-2121		17. INFORMANT ADDRESS Mrs. Marie Cannon-Rt. 1 Box 260 Creek Rd. Severna Park Md.	
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Coronary - selective heart disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: heart disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10/2	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 10/2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/2 19 71 to 11/1 19 71 that (I) (we) last saw the deceased alive on 10/6 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Joseph R. Liberto, M.D.		23B. DATE SIGNED 11/2/71			
23C. PHYSICIAN'S NAME (Type) JOSEPH R. LIBERTO M.D.		23D. ADDRESS 3508 Beach ST. Baltimore Md.			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-4-71		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park	
24D. LOCATION (City, town, or county) Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS John C. Miller Inc-6415 Belair Rd. -21206	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

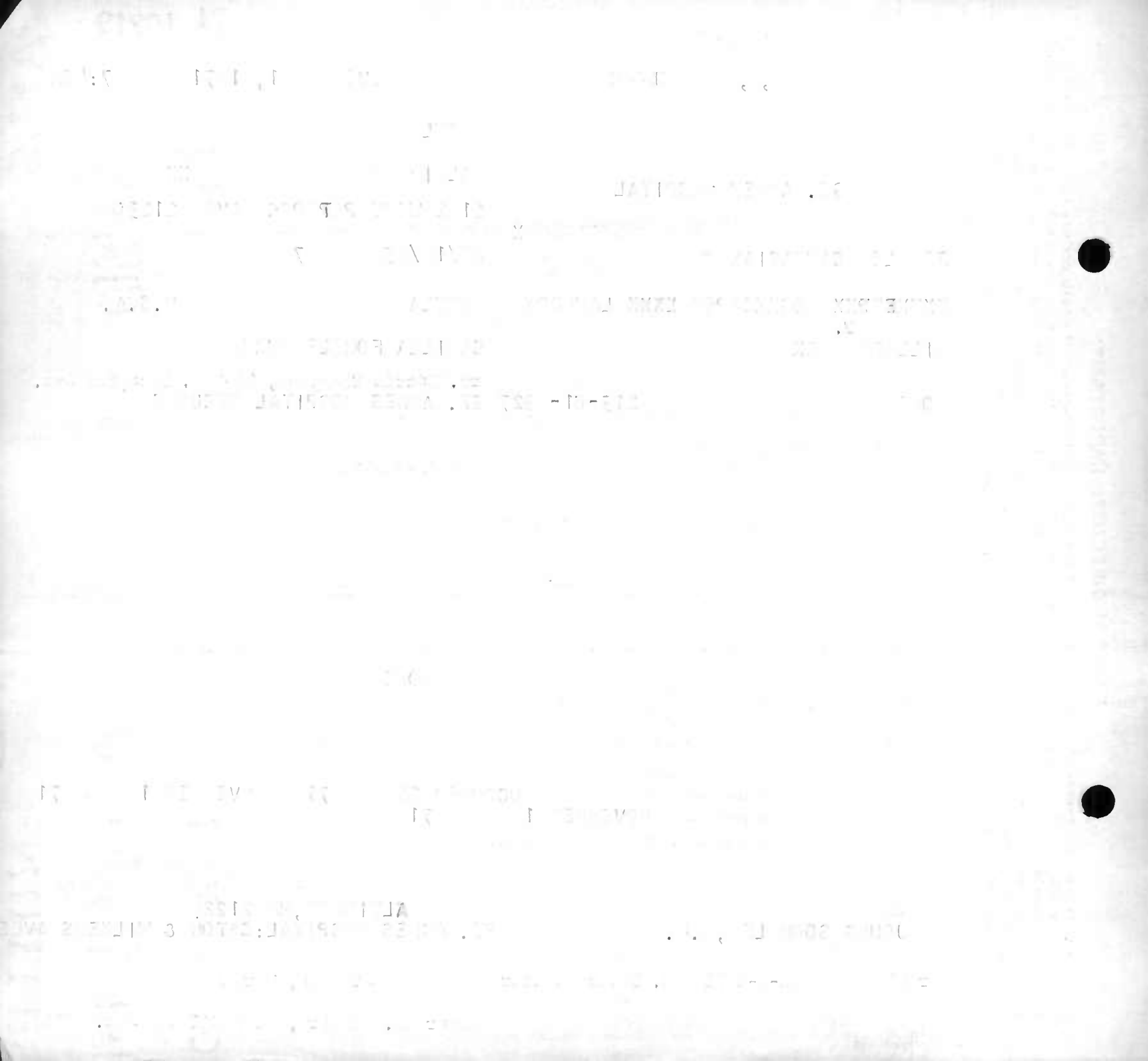
BIRTH NO. R-208 71 10218		BALTIMORE CITY HEALTH DEPT.		71 10218	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
ROSS, CECIL VIRGINIA		NOVEMBER 1, 1971 3:50 P.M.		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 40		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
ST AGNES HOSPITAL		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
FEMALE		CAUCASIAN		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
SAMUEL RITCHIE		ELIZABETH BRITTINGHAM		16. SOCIAL SECURITY NO.	
				213-48-5307	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH	
BALTIMORE MD 21229		ST AGNES RECORDS WILKENS & CATON AVES		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
				(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)	
				ANTECEDENT CAUSES	
				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
				II	
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from OCTOBER 31 19 71 to NOVEMBER 1 19 71 that (X) (we) last saw the deceased alive on NOVEMBER 1 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
PERFECTO VALARAO, M.D.				11-1-71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
PERFECTO VALARAO, M.D.				BALTIMORE MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11-4-1971		Loudon Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME of REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 5 1971		Robert E. Taylor, M.D.		Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 10219	
BIRTH NO. 71 10219		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Burk, RUBY HELEN</i>		2. DATE AND HOUR OF DEATH NOVEMBER 1, 1971		7:45A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2572			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2162 WEST PATAPSCO AVE 21230			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/19/95	9. AGE (in years lost birthday) 76	10. UNDER 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOKKEEPER BOOKKEEPER		10B. KIND OF BUSINESS OR INDUSTRY XAMM LAUNDRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MILLARD BURK		14. MOTHER'S MAIDEN NAME CAMILLA FOWBLE BURK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 215-01-6927		17. INFORMANT Mrs. Hattie Thompson, 2162 W. Patapasco Ave. ST. AGNES HOSPITAL RECORDS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: CVA (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NONE	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 22 1971 to NOVEMBER 1 1971 that (I) (we) last saw the deceased alive on NOVEMBER 1 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joung Soon Lee</i>		23B. DATE SIGNED Nov. 1, 1971		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) JOUNG SOON LEE, M.D.		23D. ADDRESS BALTIMORE, MD 21229 ST. AGNES HOSPITAL: CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-4-1971		24C. NAME of CEMETERY or CREMATORY St. Pauls Cemetery	
24D. LOCATION Arcadia, Maryland		24E. DATE REC'D BY HEALTH DEPT. NOV 5 1971		24F. NAME OF REGISTRAR Robert E. Fisher, M.D.	
24G. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		24H. ADDRESS		24I. DATE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

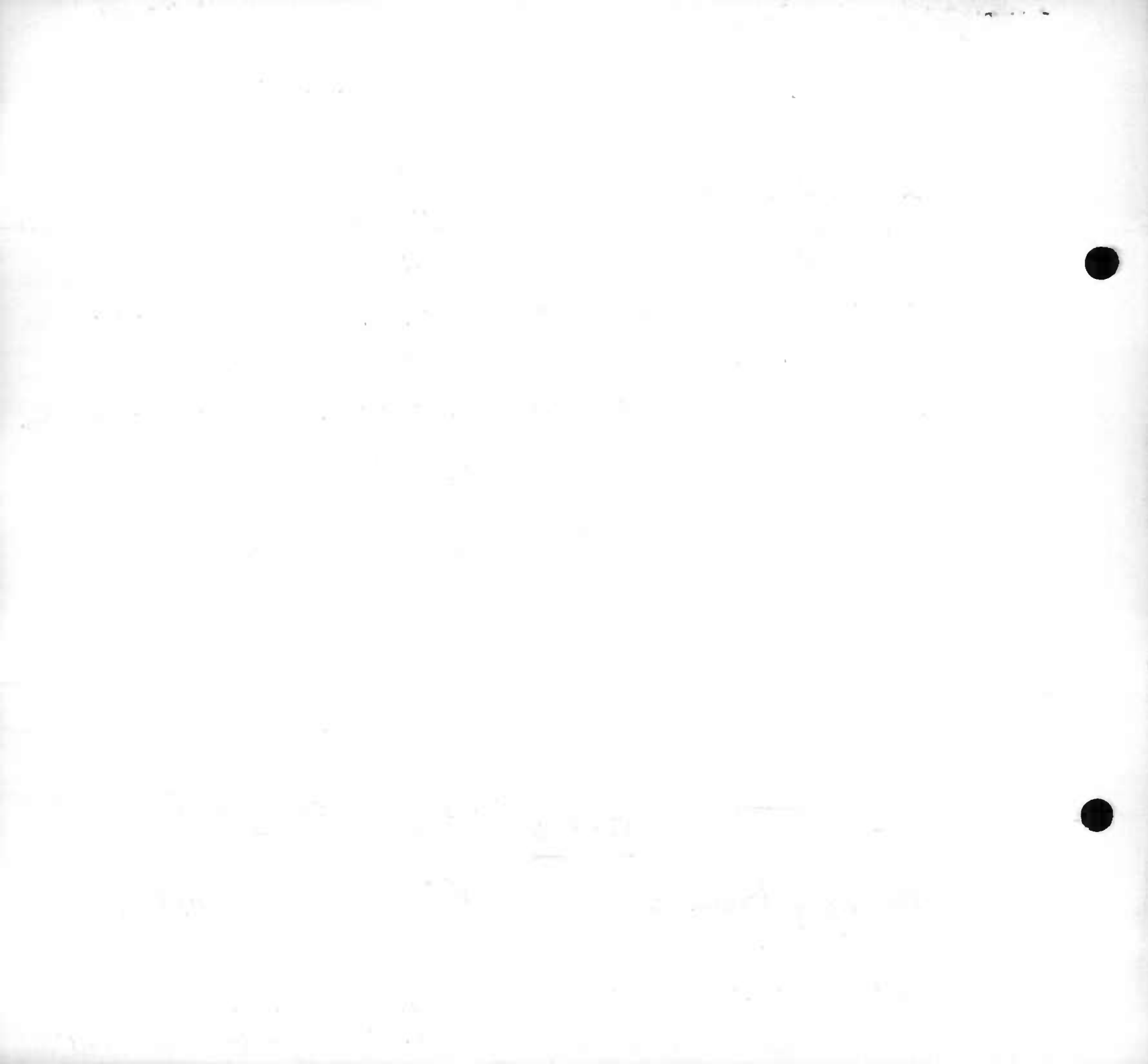
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 10220</u>	
<div style="display: flex; justify-content: space-between;"> P-625-71 10220 CERTIFICATE OF DEATH </div>					
BIRTH NO. <u>71-18350</u>		1. NAME OF DECEASED (Type or Print) <u>Baby Girl Preisinger</u>			
2. DATE AND HOUR OF DEATH <u>11-1-71</u> <u>7:55 A.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>		A. STATE <u>Md</u>		B. COUNTY <u>2744</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>5517 Edna Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-30-71</u>	9. AGE (in years last birthday)	10. Under 1 Yr. Months Days <u>1</u> <u>20</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Robert Preisinger</u>		14. MOTHER'S MAIDEN NAME <u>Wanda Burks</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>hospital chart</u>	
				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>II</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hyaline Membrane Disease</u>		<u>44 hrs.</u>	
		(B) <u>Prematurity - 34 wk. gestation</u> DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>10-30</u> 19 <u>71</u> to <u>11-1</u> 19 <u>71</u> that (I) <u>(we)</u> lost saw the deceased alive on <u>11-1</u> 19 <u>71</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>J. Roberts, MD</u>		23B. DATE SIGNED <u>11-1-71</u>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>Union Memorial Hosp. Balto.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>11/2/71</u>	24C. NAME of CEMETERY or CREMATORY <u>HOLLY HILL</u>	24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>J.G. CONNELLY SONS</u>	
				ADDRESS <u>300 MACE</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
7-520		71 10221		71 10221	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <i>Joseph A. Zang</i>		2. DATE AND HOUR OF DEATH <i>Nov. 2, 1971</i> <i>10: A. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>4311 Springwood Avenue</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>2631</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>4311 Springwood Avenue</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 28, 1915</i>	9. AGE (in years last birthday) <i>56</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pipe Fitter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Western Electric</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
13. FATHER'S NAME <i>Alfred J. Zang</i>		14. MOTHER'S MAIDEN NAME <i>Wilhelmina Edelman</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes Navy WWII</i>		16. SOCIAL SECURITY NO. <i>212-09-1298</i>		17. INFORMANT <i>Mrs. Virginia V. Zang - 4311 Springwood Ave</i>	
18. <i>412.2</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Hemorrhage</i> (B) <i>Cardio Vascular Hypertensive Disease</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i> <i>12 years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>11-4-71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (we) attended the deceased from <i>May 1959</i> to <i>November 2, 1971</i> that (I) (we) last saw the deceased alive on <i>Oct. 9, 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Michael J. Dausch, M.D.</i>				23B. DATE SIGNED <i>11/2/71</i>	
23C. PHYSICIAN'S NAME (Type) <i>Michael J. Dausch</i>				23D. ADDRESS <i>John C. Miller Inc-6415 Belair Road-21206</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-4-71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>NOV 5 1971</i>			
25B. NAME OF REGISTRAR <i>Valerie E. Bailey, R.D.</i>		25C. FUNERAL DIRECTOR <i>John C. Miller Inc-6415 Belair Road-21206</i>			



BALTIMORE CITY HEALTH DEPARTMENT				71 10222			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) DONALD FORD				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year Hour November 2, 1971 10:55 P. M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 1-2-35				10. AGE (In years last birthday) 36		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1301	
11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) disabled				14B. KIND OF BUSINESS OR INDUSTRY		E. STREET AND NUMBER 2431 Callow Avenue	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				17. SOCIAL SECURITY NO. 217-14-2660		13. FATHER'S NAME Horace Ford	
15. MOTHER'S MAIDEN NAME Evelyn Thomas				18. INFORMANT ADDRESS Blanche Conway 39 S. Moreley St.			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Intravenous narcotism				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Sickle cell disease				(B) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				21. AUTOPSY? (Yes or No) yes			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/3/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-6-71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR V. Bailey ADDRESS Kelson F.H. 1348 Calhoun Street			

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AMERICAN AIRLINES

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AMERICAN AIRLINES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 10223	
CERTIFICATE OF DEATH				REG. NO. 71 10223	
BIRTH NO. <u>S-520</u>		71 10223			
1. NAME OF DECEASED (Type or Print) <u>SIMMS, ELIZARETH</u>			2. DATE AND HOUR OF DEATH <u>11/2/71</u> <u>2:30 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>SINAI HOSPITAL OF BALTO., BALTO. MD.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL OF BALTO., BALTO. MD.</u>			C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>2917 Oakley Ave. #15</u>					
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/2/1906</u>	9. AGE (in years last birthday) <u>65</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Jim Simms</u>			14. MOTHER'S MAIDEN NAME <u>Mary</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-30-7578</u>		17. INFORMANT <u>Ruth Thomas</u> ADDRESS <u>2817 Oakley Ave.</u>	
18. CAUSE OF DEATH <u>43691</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral vascular accident</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10/7/71</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> 19 <u>71</u> to <u>11/2</u> 19 <u>71</u> and that (I) (we) last saw the deceased alive on <u>11/1</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> MD.			23B. DATE SIGNED <u>11/2/71</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>DAVID GLABER M.D.</u>			23D. ADDRESS <u>SINAI HOSP. OF BALTO.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>11-6-71</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Bailey, M.D.</u>		25C. FUNERAL DIRECTOR <u>Kelson F.H.</u> ADDRESS <u>1348 Calhoun Street</u>	



BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		71 10224	
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
Henry Hall		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 10 Day 30 Year 71 Hour 4:20 P.M.		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
00 921 N. Duncan St.		Month 10 Day 30 Year 71 Hour 4:20 P.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Md. B. COUNTY 703	
6. SEX male		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 8-22-23		10. AGE (In years lost birth day) 47		11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Hall		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Alma Suber		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO.		18. INFORMANT Alfreda Hall		19. CAUSE OF DEATH		20. DATE OF OPERATION	
21. MOTHER'S MAIDEN NAME Alma Suber		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		24. DATE OF OPERATION	
25. MOTHER'S MAIDEN NAME Alma Suber		26. HOW DID INJURY OCCUR?		27. TIME (Month) (Day) (Year) (Hour) (Approx.)		28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
29. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		30. CONDITION FOR WHICH OPERATION WAS PERFORMED		31. AUTOPSY? (Yes or No) yes		32. DATE OF OPERATION	
33. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		34. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		35. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		36. DATE OF OPERATION	
37. TIME (Month) (Day) (Year) (Hour) (Approx.)		38. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		39. HOW DID INJURY OCCUR?		40. DATE OF OPERATION	
41. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		42. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		43. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		44. DATE SIGNED 10/31/71	
45. BURIAL CREMATION, REMOVAL (Specify) Burial		46. DATE 11-8-71		47. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		48. LOCATION (City, town, or county) (State) Baltimore, Md.	
49. DATE REC'D BY HEALTH DEPT NOV 5 1971		50. NAME OF REGISTRAR Robert E. Bailey, M.D.		51. FUNERAL DIRECTOR V. Bailey		52. ADDRESS Kelson F.H. 1348 Calhoun Street	

1880-1881

1880-1881

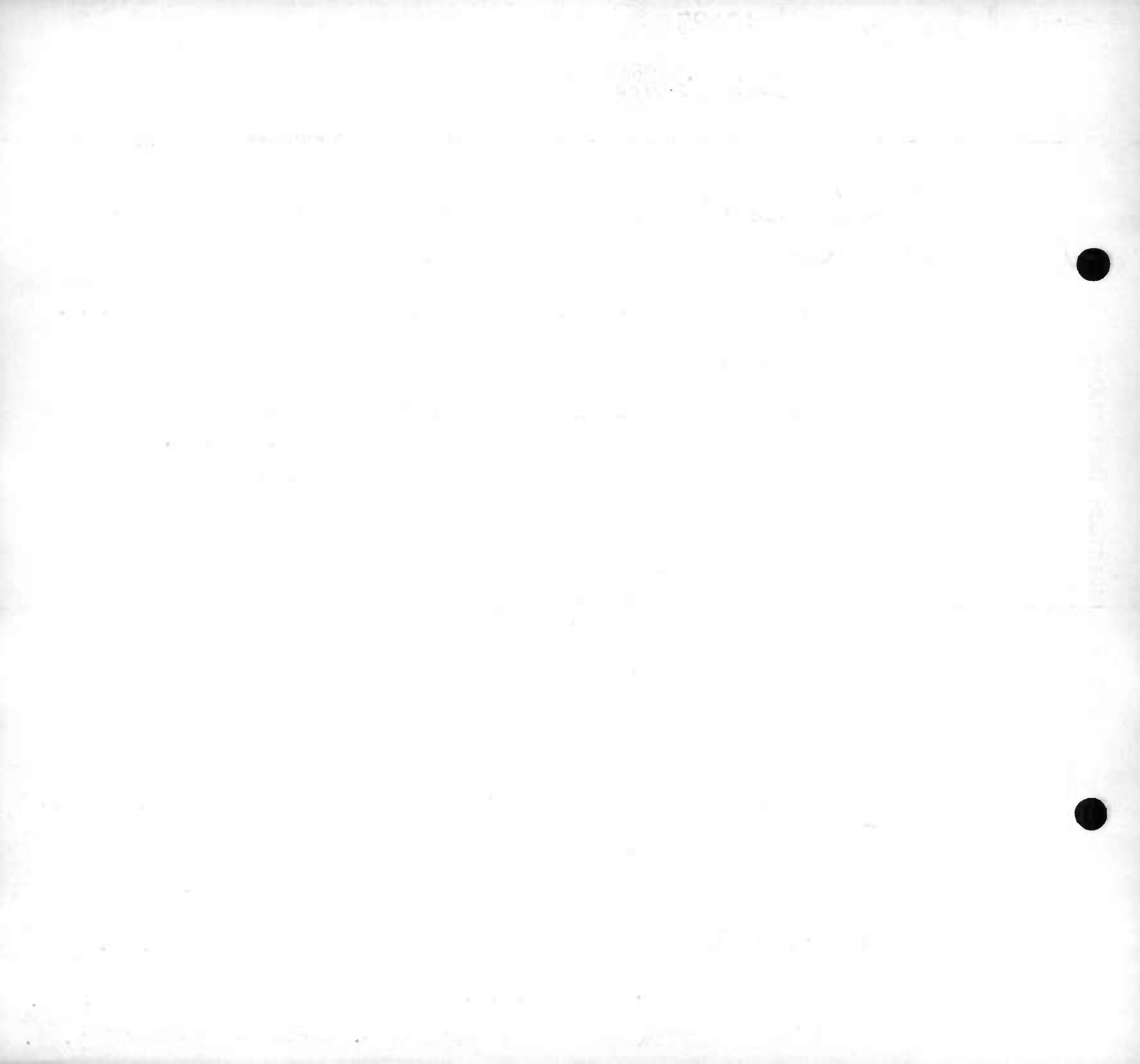
1880-1881



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-320</u> <u>71 10225</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 10225</u>	
1. NAME OF DECEASED (Type or Print) <u>Grace A. Meadows</u> <u>MEADOWS GRACE A.</u>			2. DATE AND HOUR OF DEATH <u>2 Nov 71</u> <u>945 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Harford</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue Baltimore, Maryland</u>			C. CITY OR TOWN <u>Monkton</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <u>Box 186 Jarrettsville Pike 21111</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-25-14</u>	9. AGE (in years last birthday) <u>56</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James Harris</u>			14. MOTHER'S MAIDEN NAME <u>Agnes Peace</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-32-2305</u>		17. INFORMANT <u>4940 Eastern Ave</u> <u>BCH: Records Baltimore, Maryland 21224</u>	
18. <u>2070 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH <u>James Meadows Monkton, Md 21111</u> (A) IMMEDIATE CAUSE <u>ACUTE LEUKEMIA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>28 Oct</u> 19 <u>71</u> to <u>2 Nov</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>2 Nov</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harvey M. Gocomb M.D.</u>			23B. DATE SIGNED <u>2 Nov 71</u>		23C. PHYSICIAN'S NAME (Type) <u>Harvey M. Gocomb M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>11/6/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. James A.M.E.</u>
24D. LOCATION <u>Jarrettsville, Harford, Md.</u>			25A. DATE REC'D BY HEALTH DEPT. <u>NOV 5 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>			25C. FUNERAL DIRECTOR <u>Charles E. Kurtz Jarrettsville, Md.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10226	
<div style="display: flex; justify-content: space-between;"> L-320 71 10226 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
LUDWIG, HARRY		11/2/71		14:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
42 SINAI HOSPITAL BALTIMORE			MD DELAWARE 2720		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3634 FORDS LANE, APT. 3F #15		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. Under 1 Yr. Months Days
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	XXXXXX/XX	74	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
DIRECTOR		JEWISH COMMUNITY CENTER		RUSSIA	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
? LUDWIG			USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
NO			219-28-8428		MRS. RAE LUDWIG, 3634 FORDS LANE, APT. 3F #15
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
436.94-250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CEREBRO VASCULAR ACCIDENT					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DIABETES MELLITUS					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10/28 19 71 to 11/2 19 71 that (I) (we) lost saw the deceased alive on 11/2 19 71 and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Armando C. Dinamico, M.D.				11/2/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ARMANDO C. DINAMICO				SINAI HOSP. BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		11-4-71		AGUDAS BNAI JACOB	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 5 1971		Robert E. Taylor, R.D.		SOL LEVINSON & BROS.	
				6010 REISTER-STOWN ROAD	
				ROSEDALE, MARYLAND	

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FUNERAL DIRECTOR: IMPORTANT

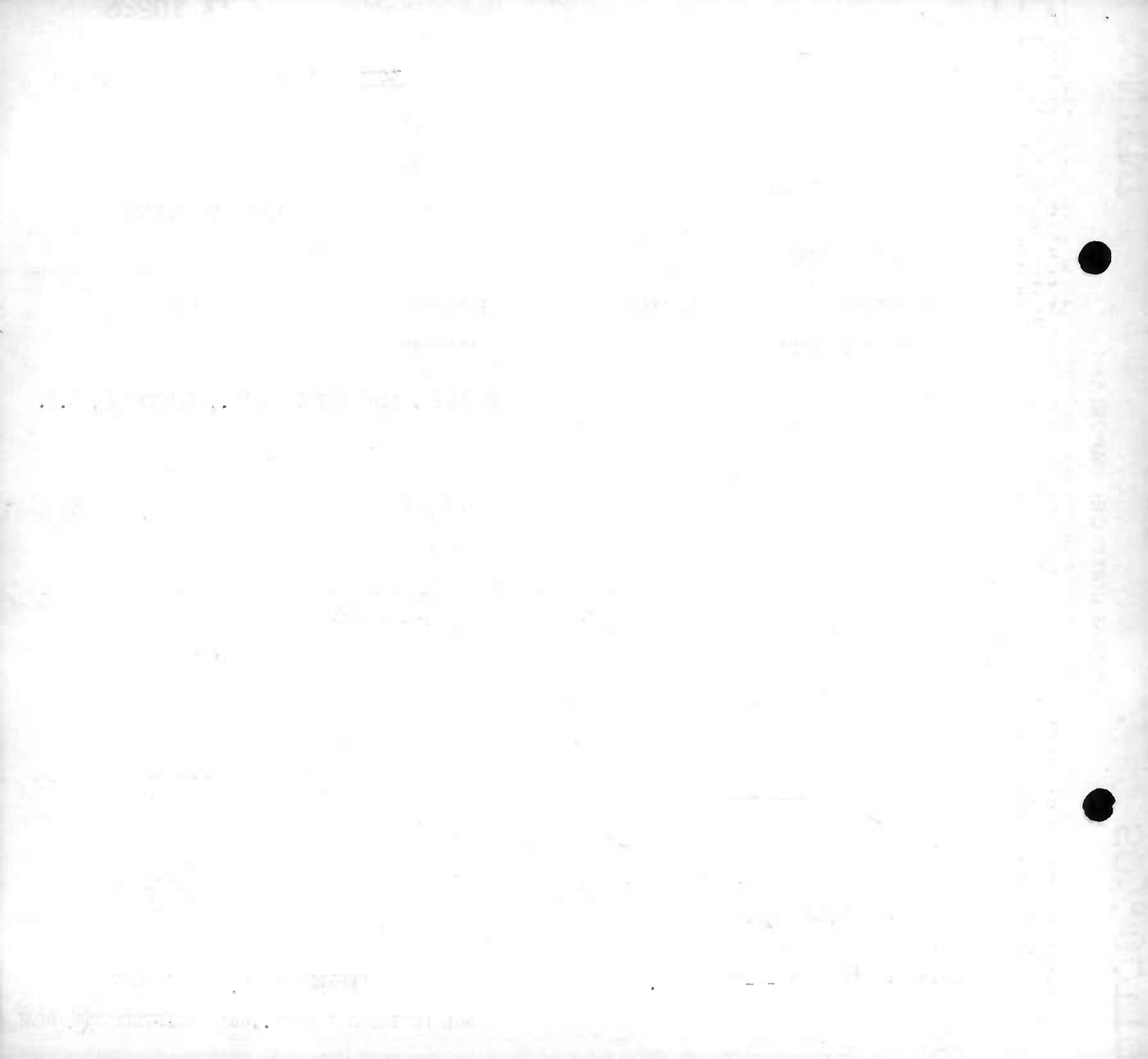
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10227	
W-516 71 10227		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) WEINBERG, BERTHA		2. DATE AND HOUR OF DEATH 11/2/71 12:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hospital IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Ind. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 25 WARREN PK DRIVE APT. B-1	
5. SEX Female	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/8/00
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	9. AGE (In years last birthday) 71
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB H. LIPOWITZ (D)		14. MOTHER'S MAIDEN NAME HOLLANDER (D)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-03-4218	
17. INFORMANT MR. HARRY WEINBERG, 25, WARREN PK. DR., APT. B 1		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) GRAM NEGATIVE SHOCK : SEPSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Abdominal peritoneal infection	
		(B) DUE TO, OR AS A CONSEQUENCE OF: Malignancy, sigmoid.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). DIABETES MELLITUS		(C) chronic	
19A. DATE OF OPERATION 11/3/71	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/1 19 71 to 11/2 19 71 that (I) (we) last saw the deceased alive on 11/2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE RUFINO G. MONTENEGRO MD DEGREE			23B. DATE SIGNED 11-2-71
23C. PHYSICIAN'S NAME (Type) RUFINO G. MONTENEGRO MD DEGREE			23D. ADDRESS Charles and 28 St. Balto. Md.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 11-4-71	24C. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP,	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR R. E. Fisher, Jr.	25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

FUNERAL DIRECTOR: IMPORTANT

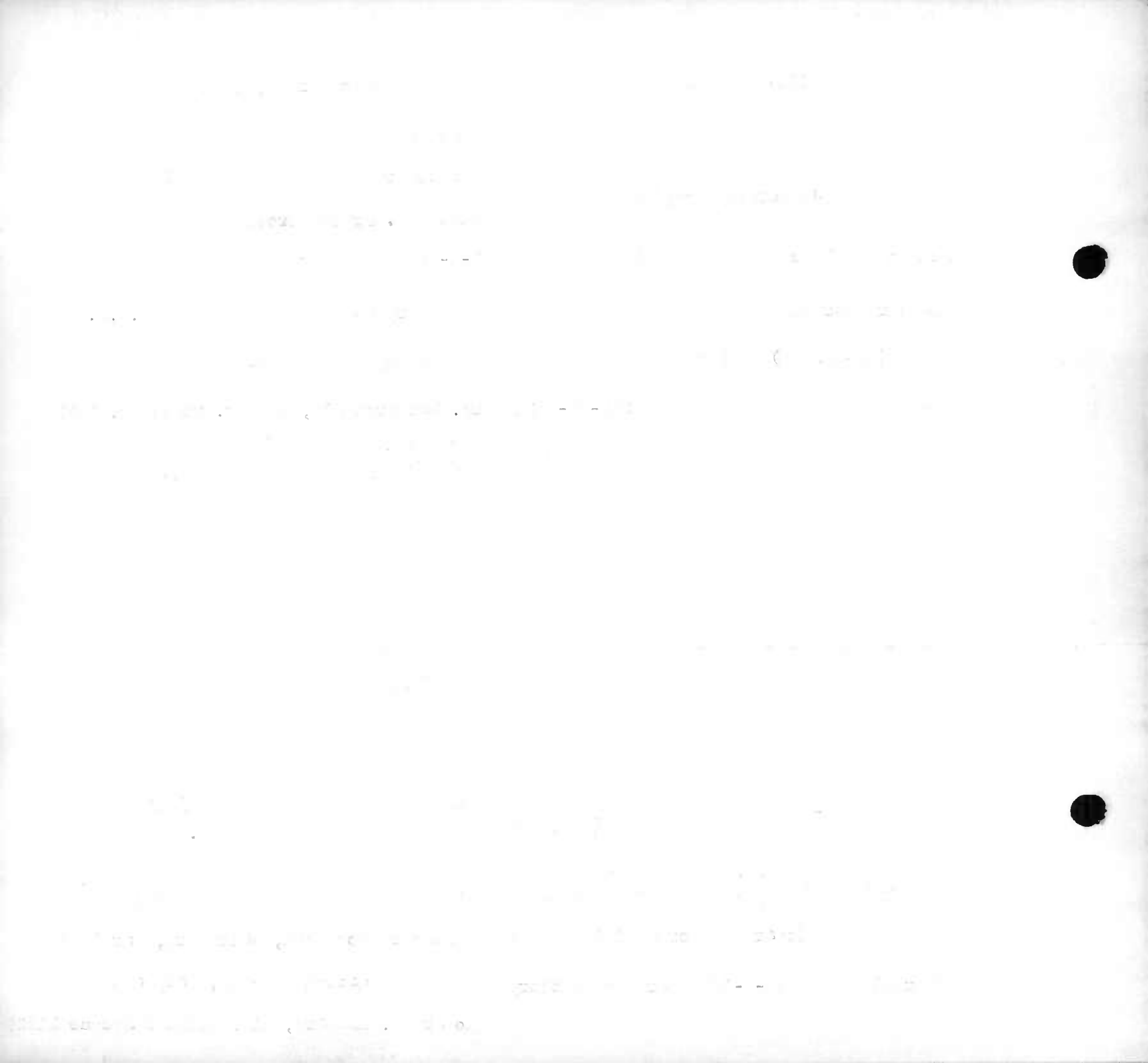
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>10228</u>	
BIRTH NO. <u>B-200 71 10228</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>PAULINE BASS</u>		2. DATE AND HOUR OF DEATH <u>NOV. 3, 1971 12 NOON</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2755</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>6052 GREENMEADOW PARKWAY #21209</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>HUNGARY</u>	
13. FATHER'S NAME <u>ABRAHAM DRATLER</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>BERNHEIM, 1200 CLINTON AVE., IRVINGTON, N.J.</u>	
18. <u>41231</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Angerthrus</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>NSLVD</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Angerthrus</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>NSLVD</u> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 Min</u> <u>15 HRS</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Old Myocardial Infarction 1964</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/3</u> to <u>11/3</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11/3</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on (the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <u>Raymond H. Caplan</u> DEGREE				23B. DATE SIGNED <u>11/3/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>RAYMOND CAPLAN</u> DEGREE				23D. ADDRESS <u>1010 St - Paul St - 21202</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL-BURIAL</u>		24B. DATE <u>11-4-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT. LEBANON</u>	
24D. LOCATION <u>XXXX ISLAND, NEW JERSEY</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 5 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>			



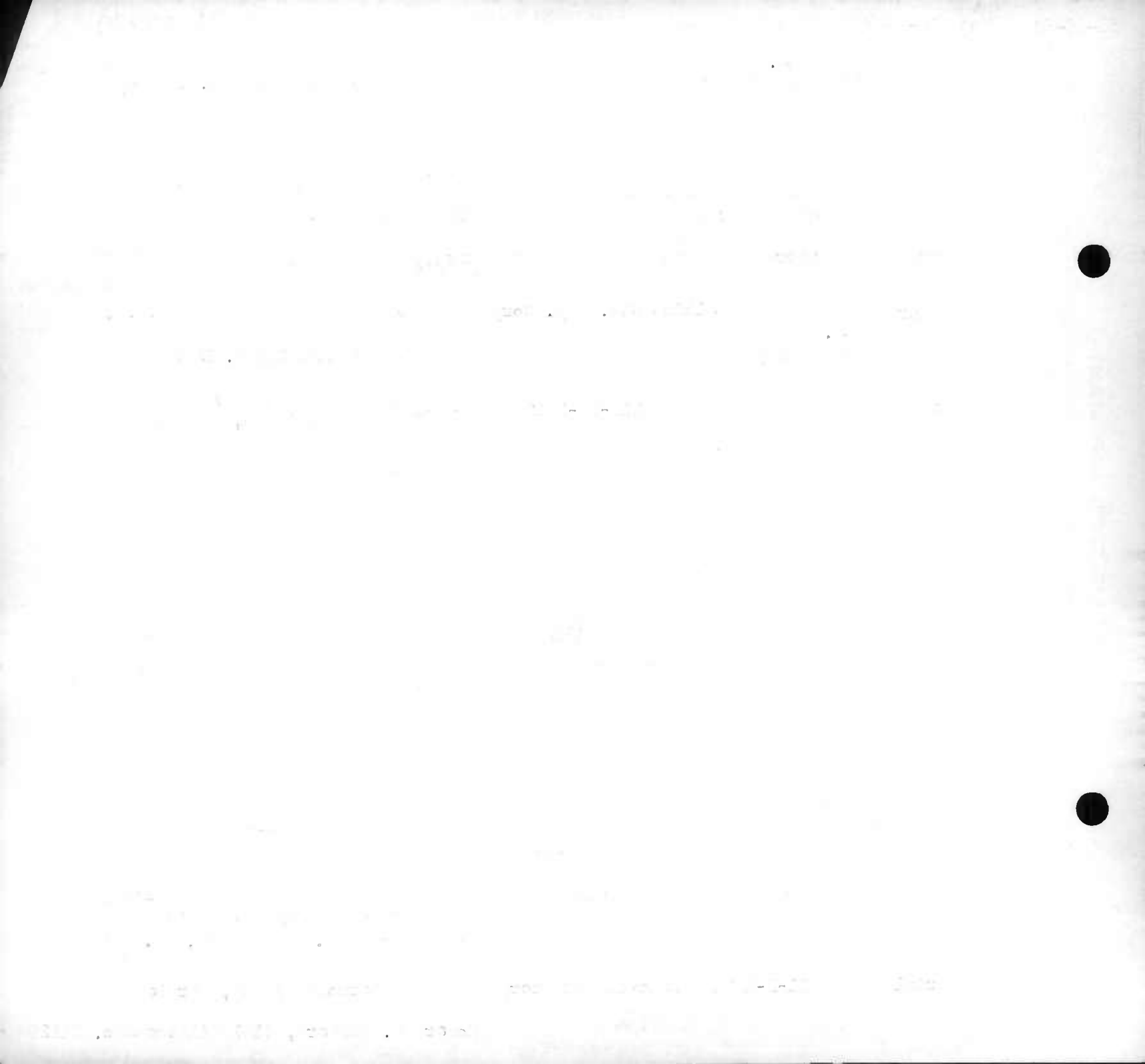
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 10229	
<div style="display: flex; justify-content: space-between;"> P-260 71 10229 </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) NETTIE PEACHER			2. DATE AND HOUR OF DEATH November 1, 1971		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital			A. STATE Maryland B. COUNTY 1803		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1104 W. Pratt Street		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-1881	9. AGE (in years last birthday) 90	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME (Unknown) Mason			14. MOTHER'S MAIDEN NAME Josephine Hall		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-09-4621		17. INFORMANT ADDRESS Mrs. Margaret Sly, 1104 W. Pratt St. 21223
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH ASCVD & PROBABLE ACUTE INFARCTION (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-20-1971 to 10-30-1971 that (I) (we) last saw the deceased alive on 10-30-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Oscar E. Fernandini M.D.				23B. DATE SIGNED 11-2-71	
23C. PHYSICIAN'S NAME (Type) Oscar E. Fernandini M.D.				23D. ADDRESS Bon Secours Hospital, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-4-1971		24C. NAME of CEMETERY or CREMATORY Harmony Cemetery	
24D. LOCATION Carroll County, Maryland		24E. CITY, town, or county (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Avenue 21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

58-59-68		S-140 71 10230		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 10230	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Carroll Shipley		2. DATE AND HOUR OF DEATH 11/1/71 8:00 p.m. 8:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2047			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Avenue 21224				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 315 S Caton Ave. 21229			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/18/44	9. AGE (in years last birthday) 27	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10B. KIND OF BUSINESS OR INDUSTRY Allied Ele. Sup. Corp.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Carroll Shipley				14. MOTHER'S MAIDEN NAME Virginia XXXXXX M. Lana			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219-38-2012		17. INFORMANT BCH-Records	
				ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) TRACHEO-BRONCHIAL COMPRESSION DUE TO, OR AS A CONSEQUENCE OF: (C) PULMONARY METASTASIS.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). TESTICULAR EMBRYONAL CELL CARCINOMA.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 10/31/71 to 11/1/71 that (I) last saw the deceased alive on 11/1/71 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE Paul W. Nelson				23B. DATE SIGNED 11-1-71			
23C. PHYSICIAN'S NAME (Type) PAUL W. NELSON M.D.				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224			
24A. BURIAL CREATION, REMOVAL (Specify) Burial		24B. DATE 11-5-1971		24C. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery		24D. LOCATION (City, town, or county) (State) Carroll County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	



BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SAMUEL T. CAMMARTA

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
HOSPITAL ADDRESS OR LOCATION)
OR INSTITUTION

00 231 S. Wolfe Street

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

November 3, 1971

1:20 P.

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

201

6. SEX

Male

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

April 1, 1916

10. AGE (In years
lost birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

E. STREET AND NUMBER

231 S. Wolfe Street

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Driver

14B. KIND OF BUSINESS OR INDUSTRY

Taxicab

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

17. SOCIAL
SECURITY NO.

215 10 0245

18. INFORMANT

ADDRESS

Steve T. Cammarate 2127 Redthorn Rd. Balto

19.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)Charles S. Springate, M.D.
Charles S. Springate, M.D.CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 4, 1971

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/5/71

24C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION (City, town, or county)

Baltimore Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 5 1971

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

James E. Bruzdinski 1407 Eastern Ave.

10031
10031

April 1, 1975

1975

1975

ACADEMY GRIND

VAULT PAPER CO.

U.S.P.

10031

10031

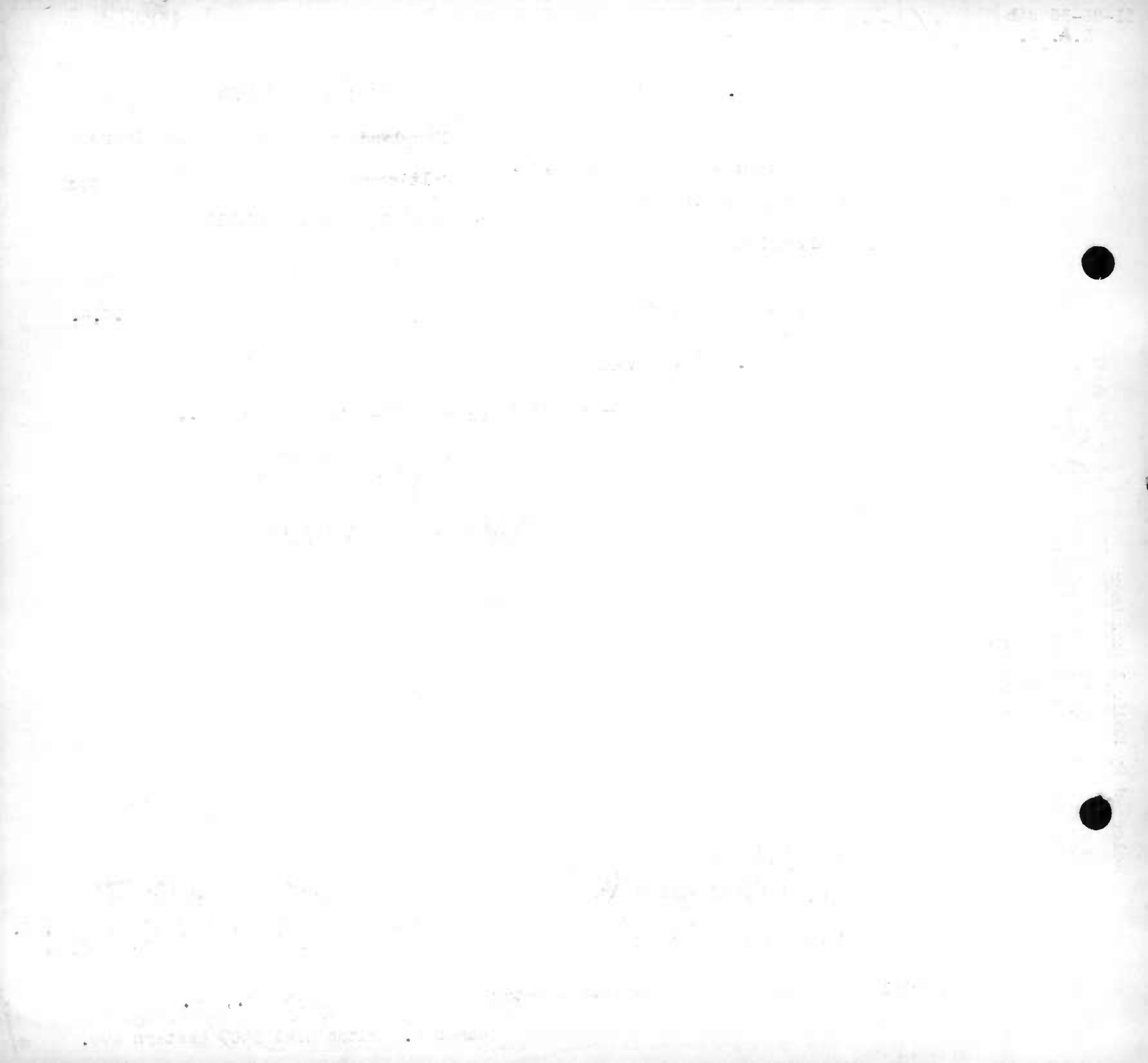
D

Released By Medical Examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

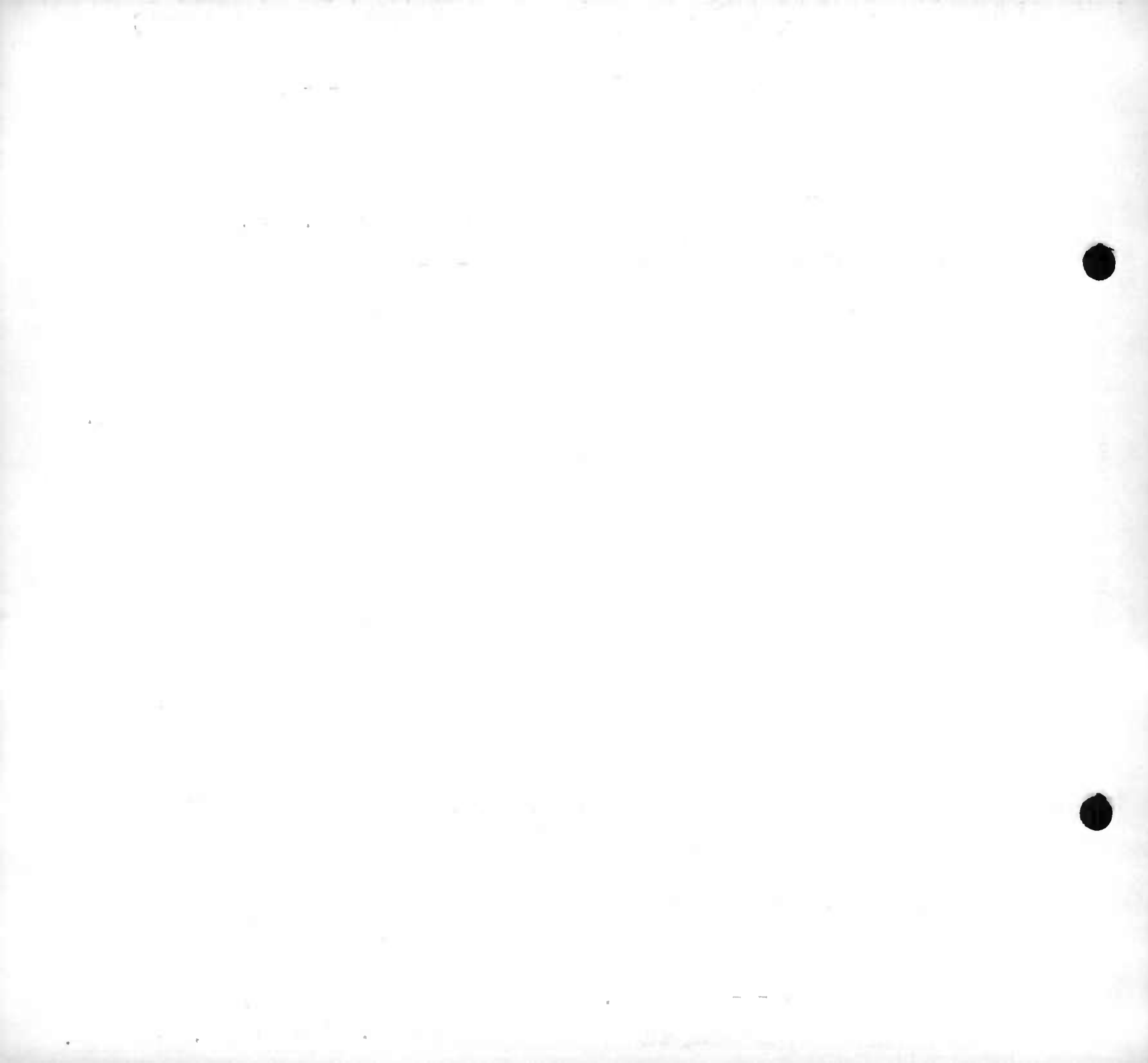
BIRTH NO. <u>H-530</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 10232</u>	
1. NAME OF DECEASED (Type or Print) <u>Carrie D. Hand</u>			2. DATE AND HOUR OF DEATH <u>11/2/71</u> <u>9:00 AM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospital</u> 21224			A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> <u>5300</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4940 Eastern Avenue, Baltimore, Md.</u>			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER <u>203 Homberg Avenue</u> <u>21221</u>					
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/21/94</u>	9. AGE in years (last birthday) <u>77</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>C. Wesley Duvall</u>			14. MOTHER'S MAIDEN NAME <u>Sylvia</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-3287-B</u>	17. INFORMANT ADDRESS <u>Records: BCH-4940 Eastern Ave., 21224</u>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Addison's Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>11/5/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/2/71</u> 19 to <u>11/2/71</u> 19 that (I) (we) last saw the deceased alive on <u>11/2/71</u> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Malcolm Herrjug</u>			23B. DATE SIGNED <u>11/2/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>Malcolm Herrjug</u>			23D. ADDRESS <u>Baltimore City Hospitals, Baltimore, Md. 4950 Eastern Ave 21224</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/5/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	
24D. LOCATION <u>Baltimore Co., Md.</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabor, R.D.</u>		25C. FUNERAL DIRECTOR <u>James E. Bruzdinski</u> 1407 Eastern Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 10233
BIRTH NO. B-652		71 10233		
1. NAME OF DECEASED (Type or Print) Harriet Burns		2. DATE AND HOUR OF DEATH 11-2-71 10:20 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 90 Melchor Nursing Home		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 1703		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Melchor Nursing Home		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female		6. RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 7-19-81		9. AGE (In years last birthday) 90		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Benjamin Armstrong		
14. MOTHER'S MAIDEN NAME Maggie Evans		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO.		17. INFORMANT Lelia Robinson ADDRESS 813 Harlem Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Seventy years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Carcinoma of Breast		1 year		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Feb 22 19 71 to Nov. 2 19 71 that (I) (we) last saw the deceased alive on Nov. 2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Loy M. Zimmerman M.D. DEGREE				23B. DATE SIGNED Nov. 4, 71
23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman M.D. DEGREE				23D. ADDRESS 3202 Harford Rd. Baltimore, Md
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11-6-71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn
24D. LOCATION (City, town, or county) Baltimore, Maryland		(State)		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Charles A. Rice		25C. FUNERAL DIRECTOR ADDRESS 661 W. Barre St.

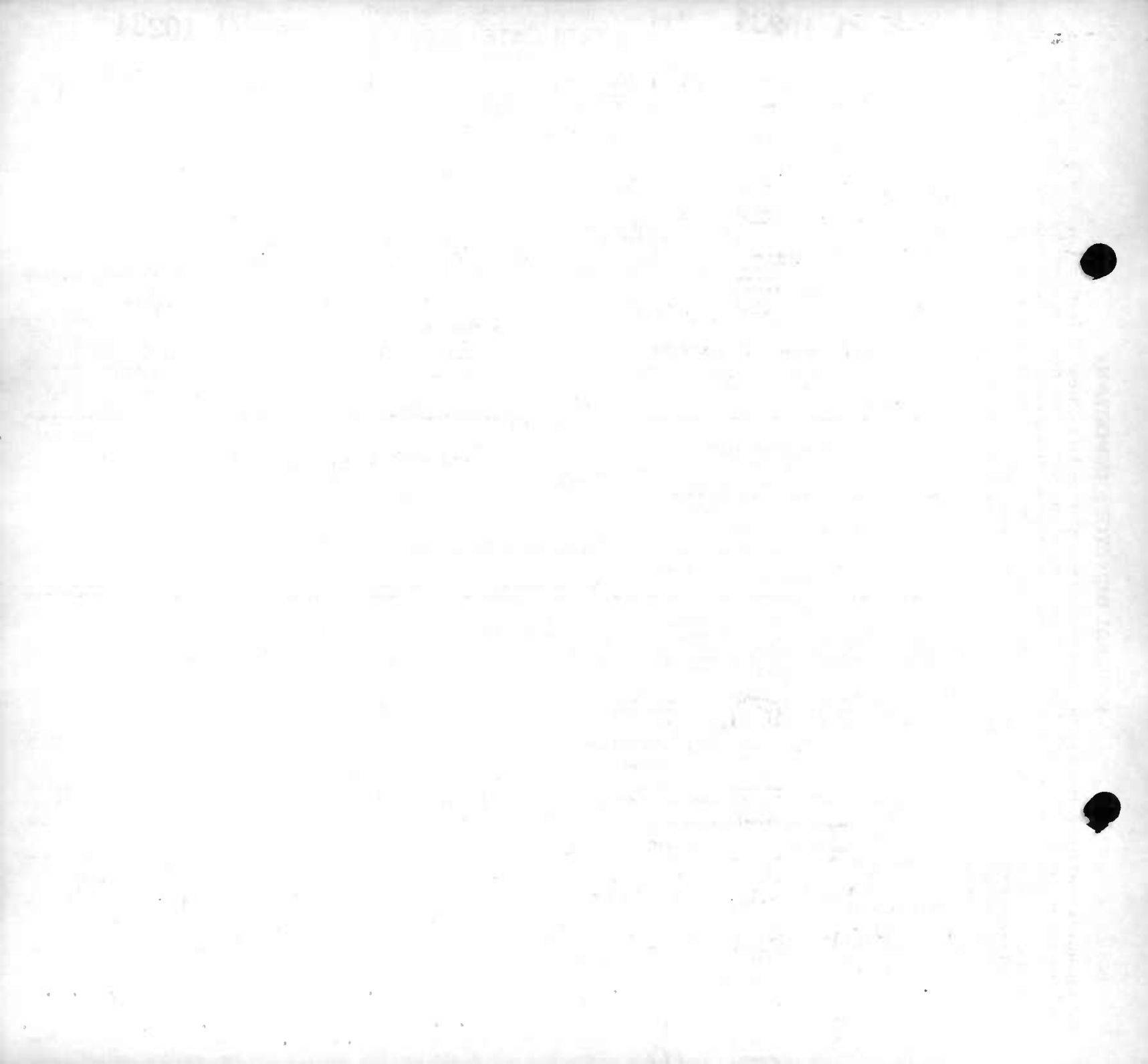


59-57-62 djs

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B-45571 10234		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 10234	
1. NAME OF DECEASED (Type or Print) GEORGE & BULLMAN			2. DATE AND HOUR OF DEATH November 3 1971 9³⁰ P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals, D BLDG. IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) A. STATE MARYLAND B. COUNTY 1205		
5. SEX Male			6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 6/15/1900			9. AGE (In years last birthday) 71		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED			10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME BENJAMIN BULLMAN		
14. MOTHER'S MAIDEN NAME ELIZABETH FLEMING			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		
16. SOCIAL SECURITY NO. 251-10-5384			17. INFORMANT ADDRESS 4940 Eastern Avenue BCH: Records Baltimore, Maryland 21224		
18. 162.1 303.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CARCINOMA OF LUNG			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CHRONIC ALCOHOLISM					
19A. DATE OF OPERATION NO		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from August 27 1971 to November 3 1971 that (H) (we) last saw the deceased alive on October 3 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard Reed Love M.D.			23B. DATE SIGNED Nov. 3, 1971		23C. PHYSICIAN'S NAME (Type) RICHARD REED LOVE M.D.
23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland Baltimore City Hospitals 21224					
24A. BURIAL CREMATION, REMOVAL (Specify) Rem. Burial		24B. DATE 11/7/71		24C. NAME of CEMETERY or CREMATORY Phila. Baptist Church Cem. Spartanburg County, S.C.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971			
25B. NAME OF REGISTRAR R. H. S. J. & S.		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 10235	
BIRTH NO. 13-240 71 10235		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ray J. Beasley			2. DATE AND HOUR OF DEATH 11/3/71 5:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Virginia B. COUNTY K 43		
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital 44			C. CITY OR TOWN Newport News		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
FULL NAME OF HOSPITAL OR INSTITUTION 44			E. STREET AND NUMBER 8316 Orcutt Ave		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-94	9. AGE (In years last birthday) 76	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT - McLEAN CONTRACTING CO.			11. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Richard Beasley			14. MOTHER'S MAIDEN NAME FORSYTHE		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I			16. SOCIAL SECURITY NO. 172-05-8219A		
17. INFORMANT DR. RAY J. BEASLEY, JR.			ADDRESS 1312 MARGARETTE AVE. TOWSON		
18. 1977 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Ca of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Primary unknown			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Week		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 1/10/77/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DX OF BILIARY OBSTRUCTION		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (able hospital) attended the deceased from 11/2 19 71 to 11/3 19 71 that (I) (we) last saw the deceased alive on 11/3 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. 44 (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. John H. Mulholland				23B. DATE SIGNED 11/3/71	
23C. PHYSICIAN'S NAME (Type) Dr. John H. Mulholland				23D. ADDRESS 33rd & Calvert Sts.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-71		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cemetery Baltimore, Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR —		25C. FUNERAL DIRECTOR H. W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212	

Richard Beasley

M

Colorado

12-28-44

Union Memorial Hospital
8310 Grand Ave

U.S.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 10236		71 10236	
BIRTH NO.				71 10236		71 10236	
1. NAME OF DECEASED (Type or Print)				Russell E. Hagner		2. DATE AND HOUR OF DEATH 11-3-71 8:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland		B. COUNTY 1203	
00 444 Ilchester Avenue				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 444 Ilchester Avenue							
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-6-1913	9. AGE (In years last birthday) 58	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oil Burner Service			10B. KIND OF BUSINESS OR INDUSTRY Calvert Oil Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Hagner				14. MOTHER'S MAIDEN NAME Sophie Polke			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-10-0891		17. INFORMANT Mrs. Audrey M. Hagner	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma, Stomach (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C Brain Metastases (B) DUE TO, OR AS A CONSEQUENCE OF: C Cochlear -				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR			
22. I certify that (I) (the hospital) attended the deceased from July 1 1971 to Nov 3 1971 that (I) (we) lost saw the deceased alive on Oct 28 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Donald W. Mintzer				23B. DATE SIGNED 11/4/71			
23C. PHYSICIAN'S NAME (Type) Dr. Donald W. Mintzer				23D. ADDRESS 3009 Evergreen Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-6-71		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 5 1971		25B. NAME OF REGISTRAR Valerie E. Vandy, M.D.		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

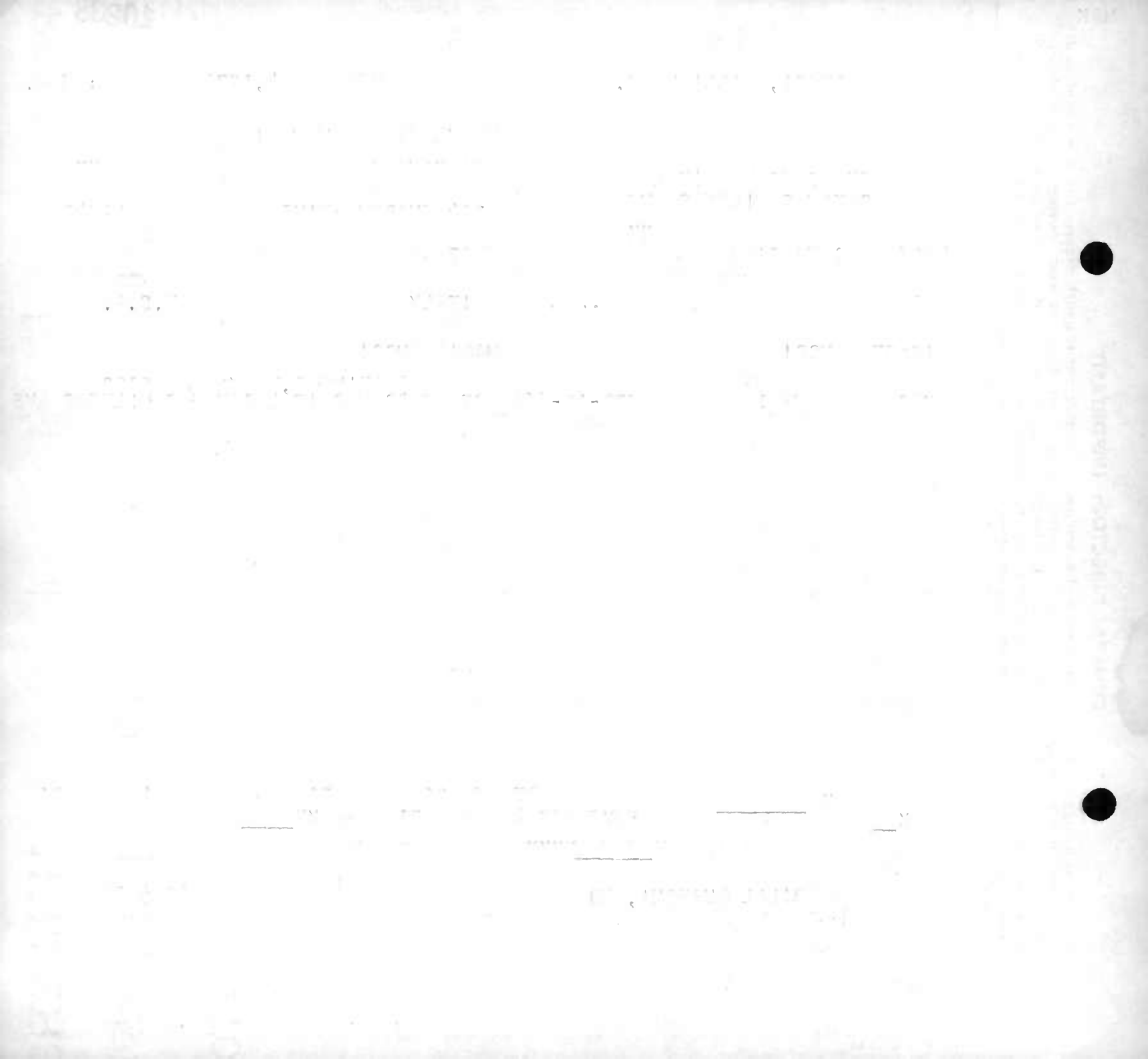
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 10237</u>	
<div style="display: flex; justify-content: space-between;"> H-655 10237 </div>					
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>ELIZABETH HARMON</u> </div> <div> 2. DATE AND HOUR OF DEATH <u>11/3/71</u> <u>9⁰⁵</u> <u>A</u> M. </div> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>90</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>Gould Convalesarium</u> <u>6116 Belair Rd</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>103</u> C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>611 S. Bradford St</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2/9/1904</u>	9. AGE (in years last birthday) <u>67</u>	10. CITIZEN OF WHAT COUNTRY <u>USA</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>			11. BIRTHPLACE (State or foreign country) <u>Md</u>		
13. FATHER'S NAME <u>—</u>			14. MOTHER'S MAIDEN NAME <u>—</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>			16. SOCIAL SECURITY NO. <u>9015 220-38-9019M</u>		
15. Informant <u>Gould Convalesarium</u>			ADDRESS <u>—</u>		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> (A) IMMEDIATE CAUSE <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (B) Antecedent Cause <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) — </div> <div> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>STAT.</u> </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Carcinoma of cervix, in situ, living tumor deposit</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>—</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (the hospital) attended the deceased from <u>10/14/1971</u> to <u>11/3/1971</u> that (I) (we) last saw the deceased alive on <u>11/1/1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Albert B. Bradley</u>				23B. DATE SIGNED <u>11/3/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Albert B. Bradley</u>				23D. ADDRESS <u>4900 Belair Road</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>cremation</u>		24B. DATE <u>11/6/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park</u>	
24D. LOCATION <u>Baltimore, Md</u>		24E. CITY, town, or county (State) <u>—</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Ave., 21228</u>	
25D. ADDRESS <u>—</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

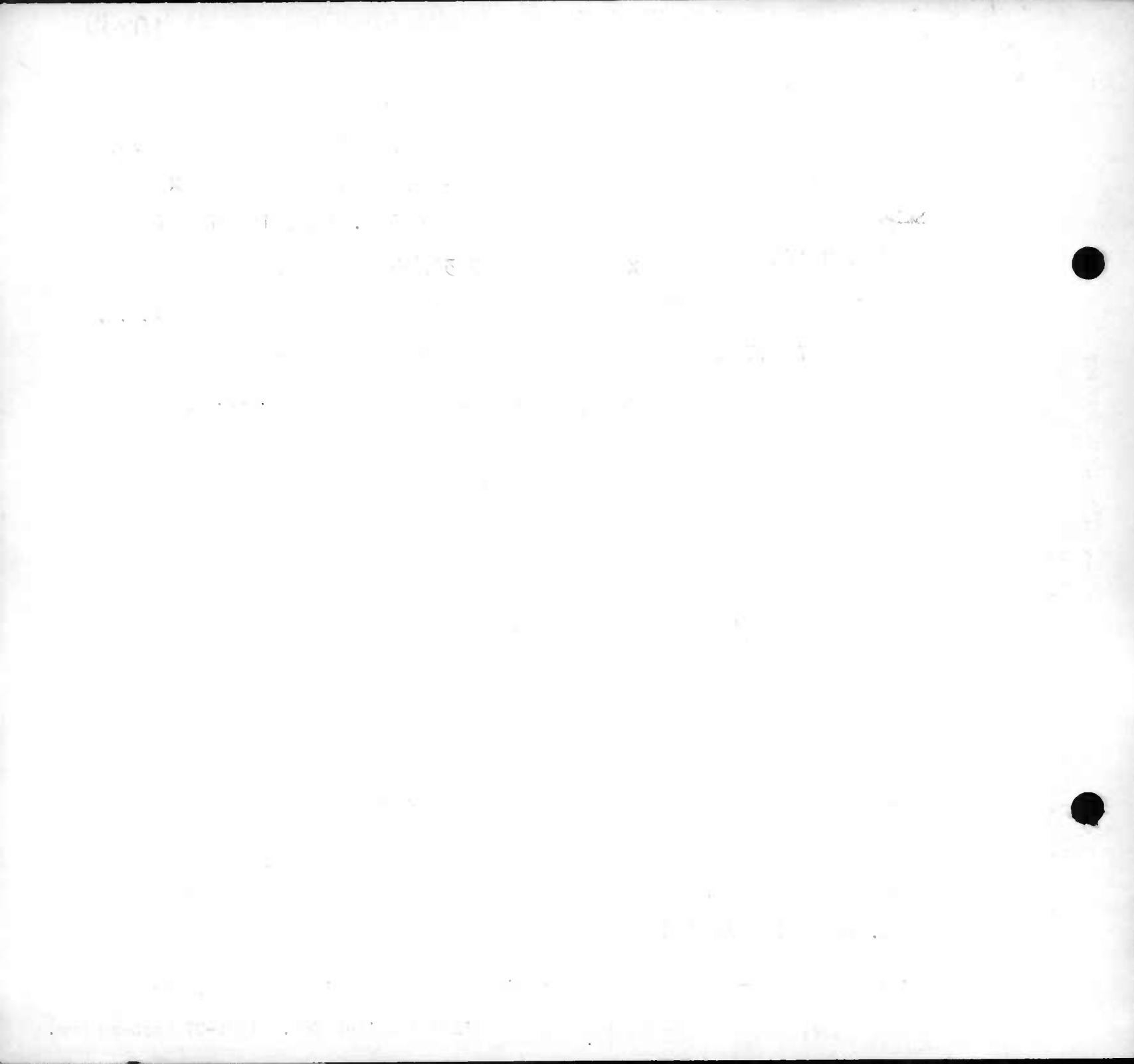
BIRTH NO. <u>B-200</u>				BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH				REG. NO. <u>71 10238</u>			
1. NAME OF DECEASED (Type or Print) <u>BUCCI, WILLIAM G.</u>				2. DATE AND HOUR OF DEATH <u>NOVEMBER 04, 1971</u> <u>6:25 P.M.</u>											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>HOWARD</u>											
FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST AGNES HOSPITAL</u> <u>CATON & WILKENS AVE</u>				C. CITY OR TOWN <u>BALTIMORE</u>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
5. SEX <u>MALE</u>				6. RACE <u>CAUCASIAN</u>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>8 17 99</u>			
9. AGE (In years last birthday) <u>72</u>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Billiard Sup. Co.</u>				11. BIRTHPLACE (State or foreign country) <u>ITALY</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>IGNOTE BUCCI</u>				14. MOTHER'S MAIDEN NAME <u>MARIA BUCCI</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW 1</u>				16. SOCIAL SECURITY NO. <u>577-12-6698</u>				17. INFORMANT <u>BALTIMORE, MARYLAND</u>				ADDRESS <u>21229 ST AGNES HOSPITAL CATON & WILKENS AVE</u>			
18. <u>153.8</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Terminal CA</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Metastatic (Generalized)</u>				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Colon</u>				(C) <u></u>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u></u>			
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>				20A. AUTOPSY? (Yes or No) <u>NO</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u></u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u></u>							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u></u>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? <u></u>							
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>OCTOBER 23</u> <u>1971</u> to <u>NOVEMBER 4</u> <u>1971</u> that <u>(X)</u> (we) last saw the deceased alive on <u>NOVEMBER 4</u> <u>1971</u> and that <u>(XX)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) (did) (did not) view the body after death.															
23A. SIGNATURE <u>BILAL QURESHI, MD</u>				23B. DATE SIGNED <u>11 4 71</u>				23C. PHYSICIAN'S NAME (Type) <u>DR QURESHI</u>				23D. ADDRESS <u>ST AGNES HOSPITAL, Balto</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>11/8/71</u>				24C. NAME of CEMETERY or CREMATORY <u>Crestlawn Cemetery</u>				24D. LOCATION (City, town, or county) (State) <u>Marriottsville, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1971</u>				25B. NAME OF REGISTRAR <u>Robert E. Fahey, M.D.</u>				25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Ave., 21228</u>				ADDRESS <u></u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-652		10239		BALTIMORE CITY HEALTH DEPARTMENT		71 10239	
BIRTH NO.		10239		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>HORNIG, ELSIE, M</i>				2. DATE AND HOUR OF DEATH <i>11/5/71 3:20 PM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hosp.</i> <i>33</i>				A. STATE <i>MARYLAND</i>		B. COUNTY <i>105</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>306 S. MADERIA STREET</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>03/30/04</i>	9. AGE (in years last birthday) <i>67</i>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>AUGUST DITZEL</i>				14. MOTHER'S MAIDEN NAME <i>FLORA BOWARD</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>21305 2777</i>		17. INFORMANT <i>Donald Ruggles</i>		ADDRESS <i>9 Nightingale Way</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>CARDIAC FAILURE DUE TO MYOCARDIAL INFARCTION</i>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>14 hrs.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>EXOGENOUS obesity</i>							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>11/5 (11:30 AM)</i> 19 <i>71</i> to <i>11/5 3:20 PM</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>11/5</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Joseph P. Finizio</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11/5/71</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. JOSEPH P FINIZIO</i>				23D. ADDRESS <i>Johns Hopkins Hosp.</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-10-1971</i>		24C. NAME of CEMETERY or CREMATORY <i>Moreland Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore County, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Lilly & Zeiler, Inc.</i>		ADDRESS <i>1901-07 Eastern Ave.</i>	



71 10240		BALTIMORE CITY HEALTH DEPARTMENT		71 10240	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) Harry E. Reed		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 11 6 1971 12:08 AM			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 6 1971 12:08 M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 202	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Dec. 29, 1943		10. AGE (In years lost birthday) 27		E. STREET AND NUMBER 1825 Gough Street	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wade Reed	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Helen V. Marks	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT Wade Reed 1825 Gough Street	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Multiple stab wounds. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 1		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1901 Gough Street 201	
22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) 11 5 1971, 11:47 PM		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? stabbed during altercation	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED Nov. 6, 1971					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-9-1971		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) (State) Anne Arundel County, Maryland					
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR R. E. & J. E. 112		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.	

01801 15

01801 15

STATE OF TEXAS

County of _____

Know all men by these presents, _____ of the County of _____ State of Texas, for and in consideration of the sum of _____ Dollars, to _____ of the County of _____ State of Texas, the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said _____ of the County of _____ State of Texas, all that certain _____

TO HAVE AND TO HOLD unto the said _____ heirs and assigns forever.

And the said _____ do hereby certify that the foregoing is a true and correct copy of the original of the same as the same appears in the records of the County of _____ State of Texas.

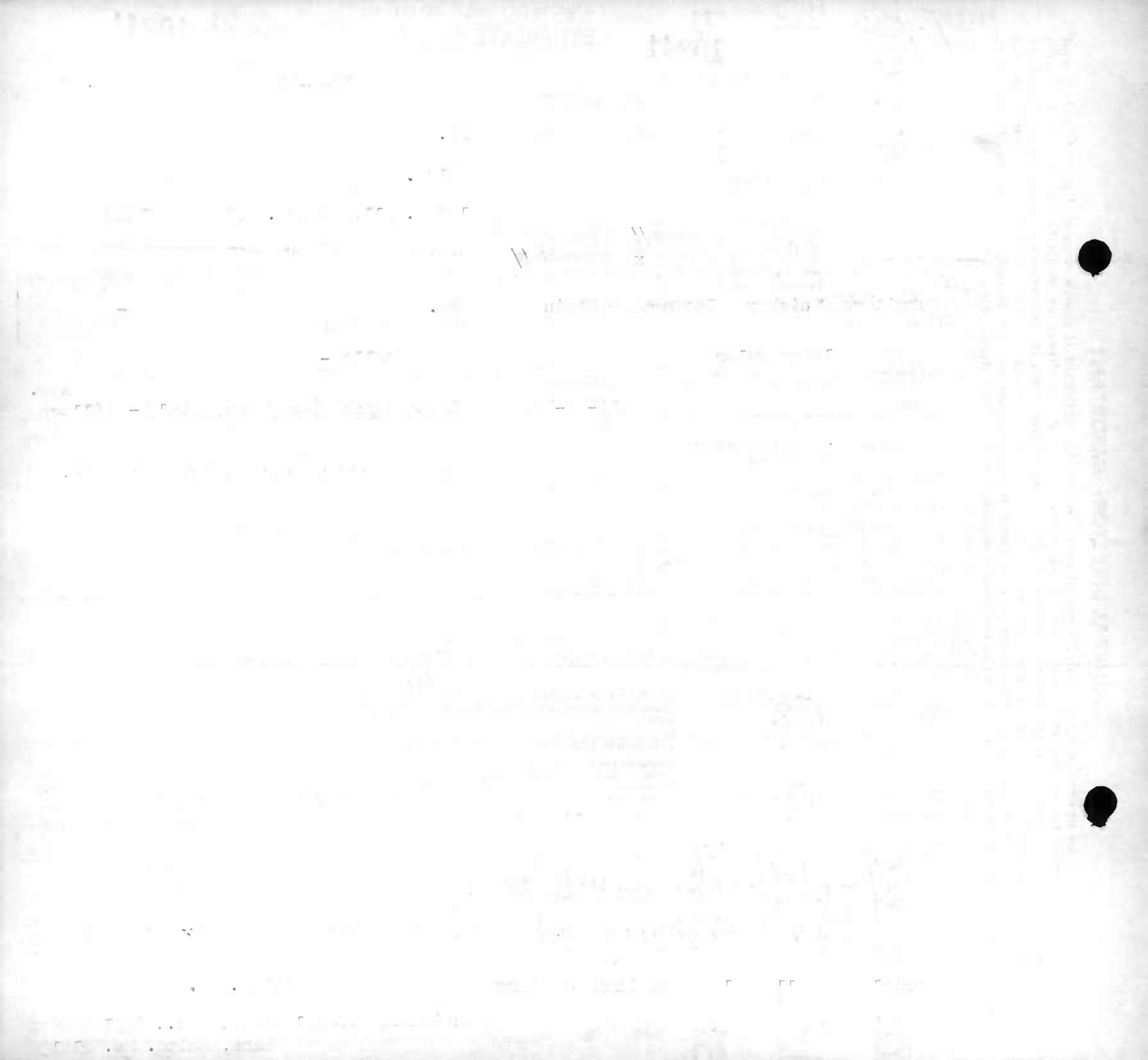
Witness my hand and seal of office this _____ day of _____ 19____.

Notary Public in and for the State of Texas.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

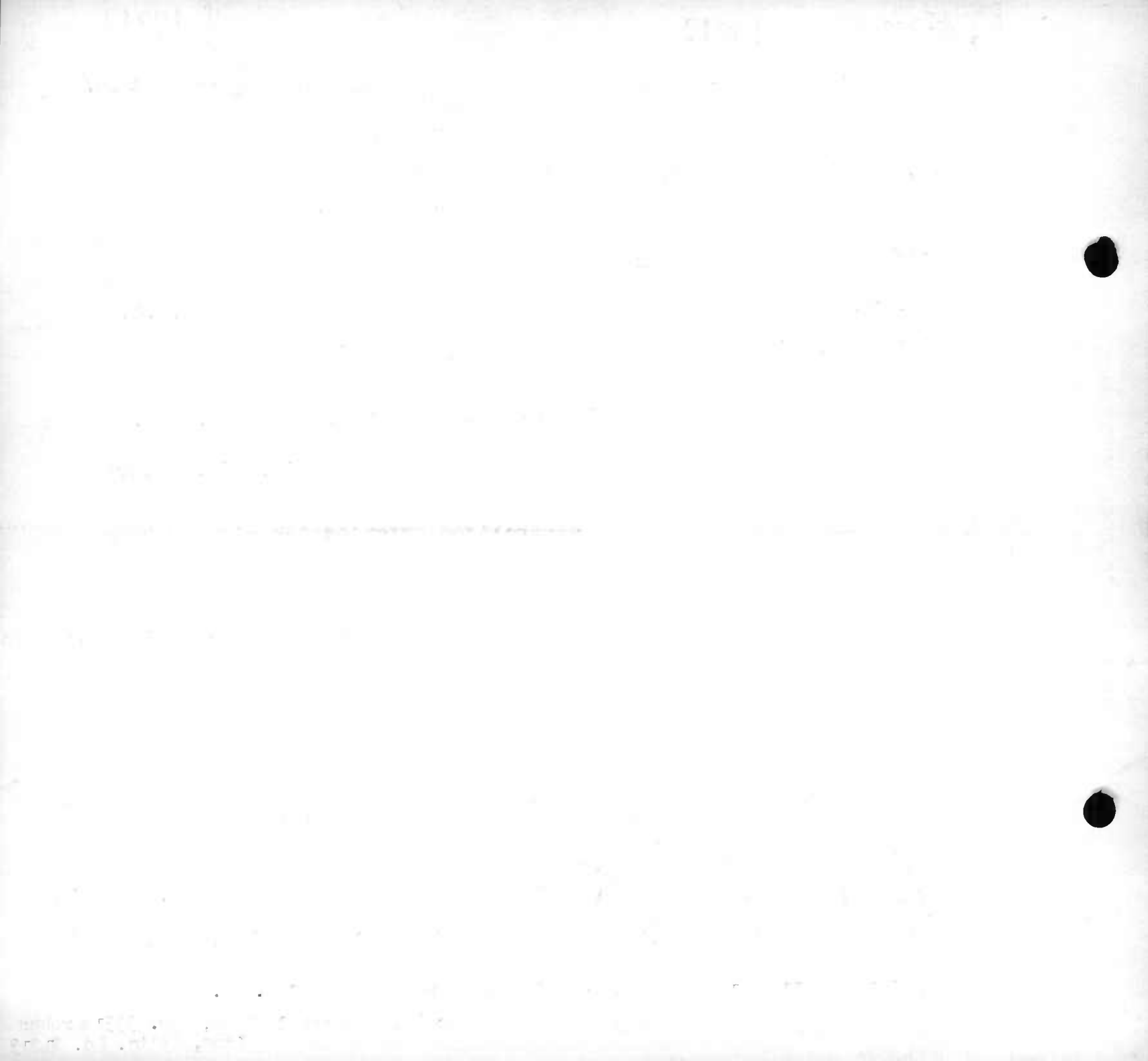
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 10241</u>	
T-460		71 10241		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Norman Tyler		11-1-71 1:25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital			A. STATE Md.		
			B. COUNTY 601		
5. SEX M			6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
			8. DATE OF BIRTH 4-6-07		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture finisher			10B. KIND OF BUSINESS OR INDUSTRY Levenson & Klein		9. AGE (In years last birthday) 64
11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? -		
13. FATHER'S NAME Albert Tyler			14. MOTHER'S MAIDEN NAME Stella -		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 213-09-7520		17. INFORMANT Irene Sepack (daughter)
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Disseminated Carcinoma DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-23-71 to 11-1-71 that (I) (we) last saw the deceased alive on 11-1-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ray S. Goodman MD				23B. DATE SIGNED 11/1/71	
23C. PHYSICIAN'S NAME (Type) RAY S. GOODMAN MD				23D. ADDRESS Mercy Hospital 301 St. Paul Place	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/5/71		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971			
25B. NAME OF REGISTRAR Robert E. Fisher MD		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc., 3331 Brehms Lane, Balto. Md. 21213			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10242</u>	
BIRTH NO. <u>K-520 71 10242</u>		1. NAME OF DECEASED (Type or Print) <u>King, Robert Thomas</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>U.S. Public Health Service Hospital</u> <u>2X</u>		2. DATE AND HOUR OF DEATH <u>November 3, 1971 12:20 P.M.</u> 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2749</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1928 Northbourne Road</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-27-89</u>	9. AGE (In years last birthday) <u>82</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William G. King</u>		14. MOTHER'S MAIDEN NAME <u>Mara A. Stinchcomb</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217 14 6032</u>		17. INFORMANT <u>US PHS HOSPITAL, Balto., Md. Records</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>440.941.53.8</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Bronchopneumonia, Bil.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u> <u>19 years ago</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>History of adenocarcinoma -colon</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>YES</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-25-71</u> 19 <u>to</u> <u>11-3</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11-3</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert E. Belliveau, M.D. (Surgeon)</u> DEGREE <u>Surgeon</u>				23B. DATE SIGNED <u>Nov. 4, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert E. Belliveau, M.D.,</u>		23D. ADDRESS <u>US PHS HOSPITAL, Balto., Md. 21211</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/8/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Belliveau, M.D.</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213</u>			

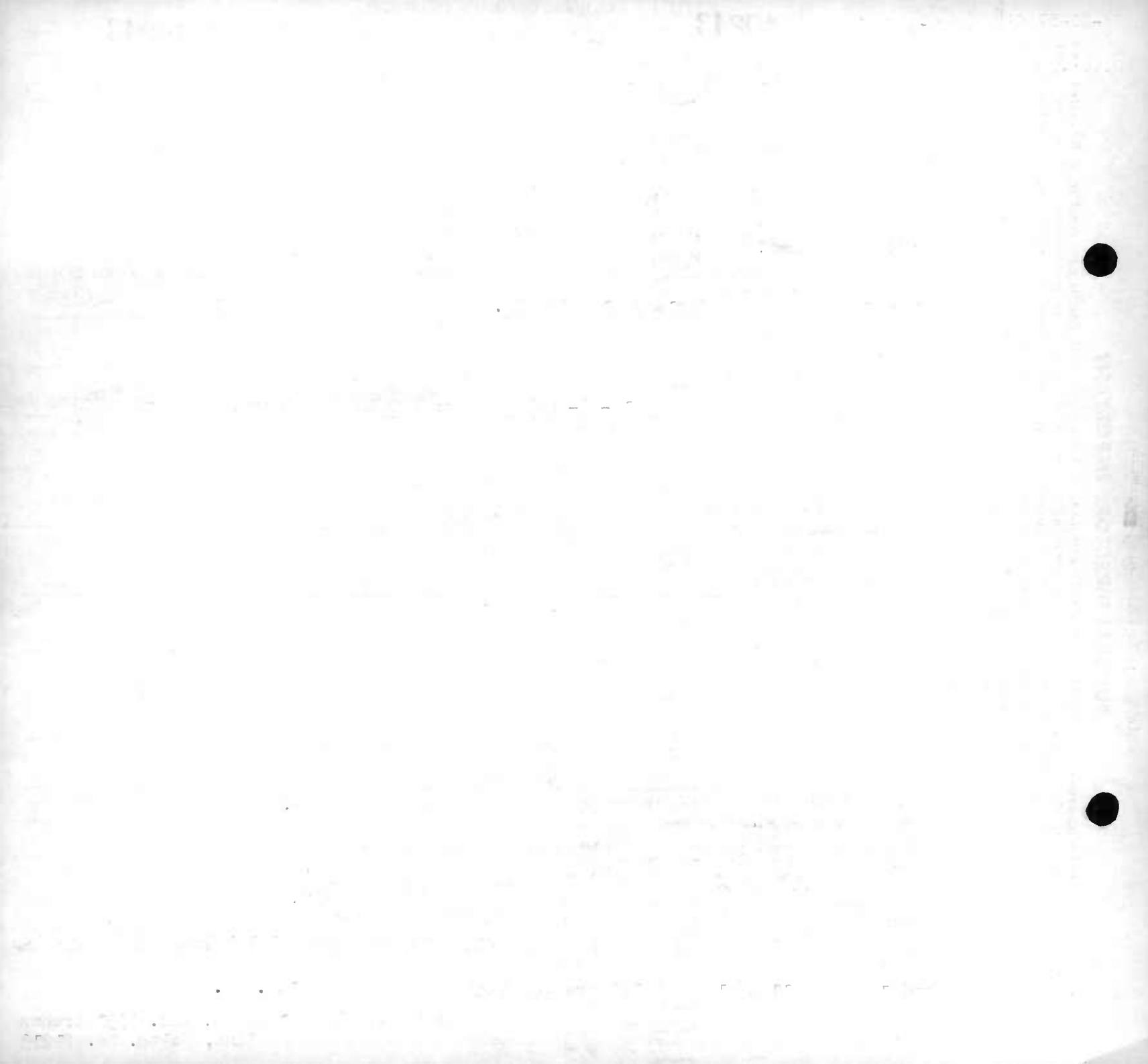


D.O.

FUNERAL DIRECTOR: IMPORTANT

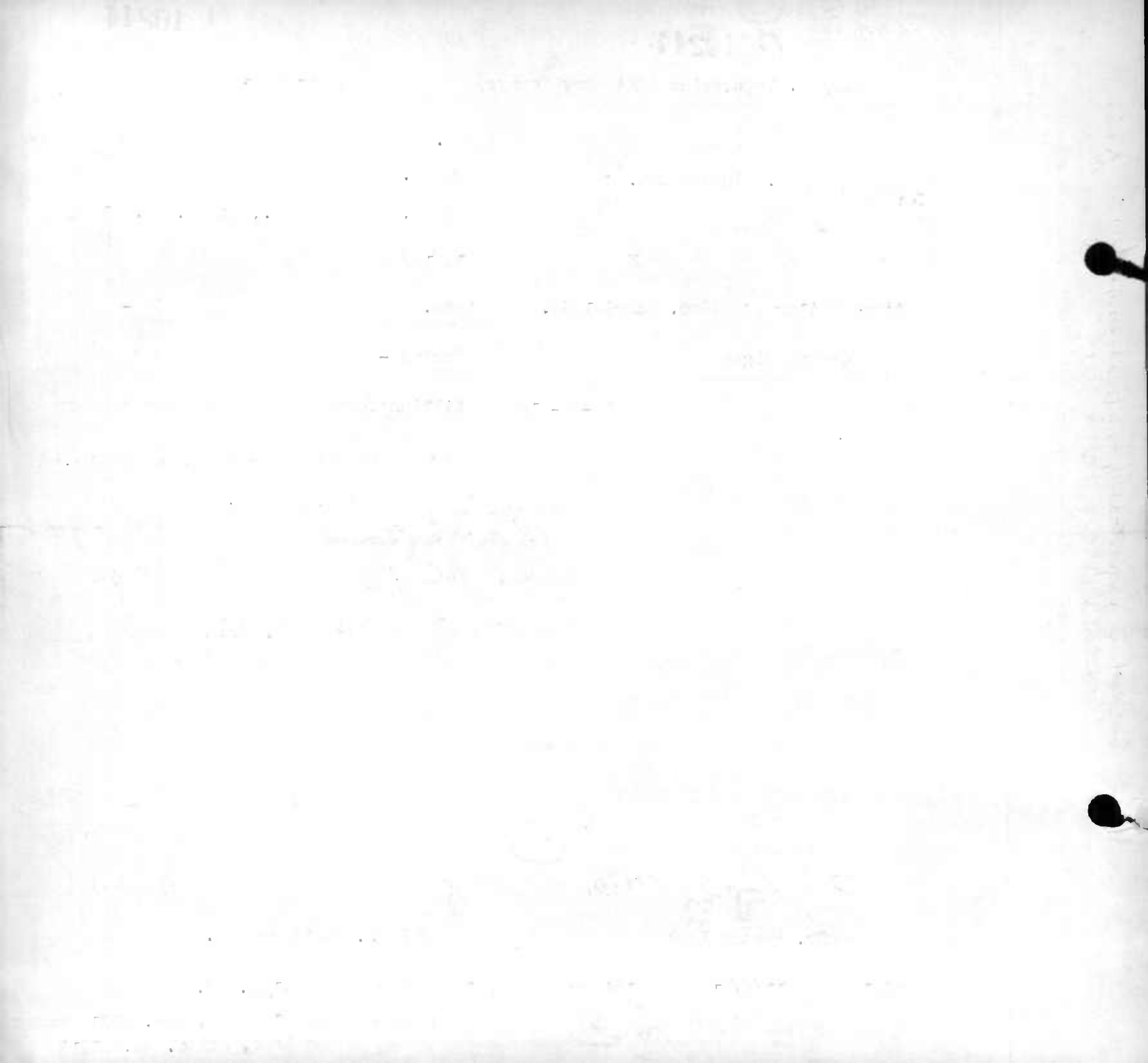
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased deceased prior to death; and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-655		10243		CERTIFICATE OF DEATH		REG. NO. 71 10243	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Mildred Sherman			
2. DATE AND HOUR OF DEATH 11-2-71 1 42:30 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 2653				5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hosp 21224			
6. SEX Female				7. RACE Caucasian			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. DATE OF BIRTH 2-14-11			
10. AGE (in years last birthday) 60				11. IF UNDER 1 Yr. Months Days			
12. IF UNDER 24 Hrs. Hours Min.				13. BIRTHPLACE (State or foreign country) Maryland			
14. CITIZEN OF WHAT COUNTRY USA				15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk			
16. KIND OF BUSINESS OR INDUSTRY Highland Cleaning Co.				17. FATHER'S NAME Robert Sherman			
18. MOTHER'S MAIDEN NAME Jenny Street				19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no			
20. SOCIAL SECURITY NO. 215-03-6658				21. INFORMANT 4940 Eastern Avenue			
22. ADDRESS BCH: RECORDS Baltimore, Maryland 21224				23. CAUSE OF DEATH			
24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				25. ANTECEDENT CAUSES			
26. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				27. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
28. DATE OF OPERATION 0				29. CONDITION FOR WHICH OPERATION WAS PERFORMED			
30. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
32. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				33. INJURY OCCURRED			
34. HOW DID INJURY OCCUR?				35. DATE SIGNED 11-2-71			
36. SIGNATURE W. H. Hall M.D.				37. PHYSICIAN'S NAME (Type) Walter H. Hall M.D.			
38. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224				39. DATE REC'D BY HEALTH DEPT. NOV 8 1971			
40. NAME OF REGISTRAR Robert E. Fisher M.D.				41. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brohms Lane, Balto. Md. 21213			



T-620
signed & approval of medical examiner's office
FUNERAL DIRECTOR: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. T-622				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10244			
1. NAME OF DECEASED (Type or Print) Mary M. Tarasewicz (AKA Mary Terrys)				2. DATE AND HOUR OF DEATH 11/2/71				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 434 N. Linwood Ave.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 601 C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 434 N. Linwood Ave., Balto. Md. 21224							
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/16/95		9. AGE (In years last birthday) 75		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired tailor				10B. KIND OF BUSINESS OR INDUSTRY Geo. Gabriel Co.				11. BIRTHPLACE (State or foreign country) Luth.		12. CITIZEN OF WHAT COUNTRY? -	
13. FATHER'S NAME Joseph Gigas				14. MOTHER'S MAIDEN NAME Martha -							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 216-05-8148		17. INFORMANT Lillian Terrys (daughter) same address				ADDRESS	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: congestive heart failure & arrhythmia (B) DUE TO, OR AS A CONSEQUENCE OF: Severe ACVD (C) recurrent rectal bleeding				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min? 2-3 yrs? 5 yrs?							
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II recurrent rectal bleeding											
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from Mar 19 56 to Nov 2 19 71 , that (I) (we) last saw the deceased alive on Sept 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE BV Lock M.D.				23B. DATE SIGNED 11/4/71							
23C. PHYSICIAN'S NAME (Type) Dr. Burton Lock				23D. ADDRESS 2936 E. Baltimore St.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/5/71		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		25D. ADDRESS 3331 Brehms Lane, Balto. Md. 21213					



S-262

71 10245

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10245

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ETHEL MARY SAKERS		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 Front of 3202 Clifton Ave.		3. DATE PRONOUNCED DEAD 10 31 1971 2:38p M.					
6. SEX female		7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Apr. 26, 1905		10. AGE (In years lost birthday) 66		11. BIRTHPLACE (State or foreign country) Md.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF U. S. A.		13. FATHER'S NAME John Horlamus		E. STREET AND NUMBER 2830 Clifton Ave.,			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		14B. KIND OF BUSINESS OR INDUSTRY A.B. Konstant Co.		15. MOTHER'S MAIDEN NAME Susan McCartin			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 218-16-2285		18. INFORMANT James E. Sakers, Jr. 303 Jerlyn Ave.,			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) DUE TO, OR AS A CONSEQUENCE OF:							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Russell S. Fisher M.D. EXAMINER'S NAME (Type): Russell S. Fisher, M.D. DATE SIGNED: 11-1-71							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-5-1971		24C. NAME of CEMETERY or CREMATORY Lorraine Park		24D. LOCATION (City, town, or county) (State) Woodlawn Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR G. Howard Strong		ADDRESS 3207 W. North Ave.,	

10512

10512

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

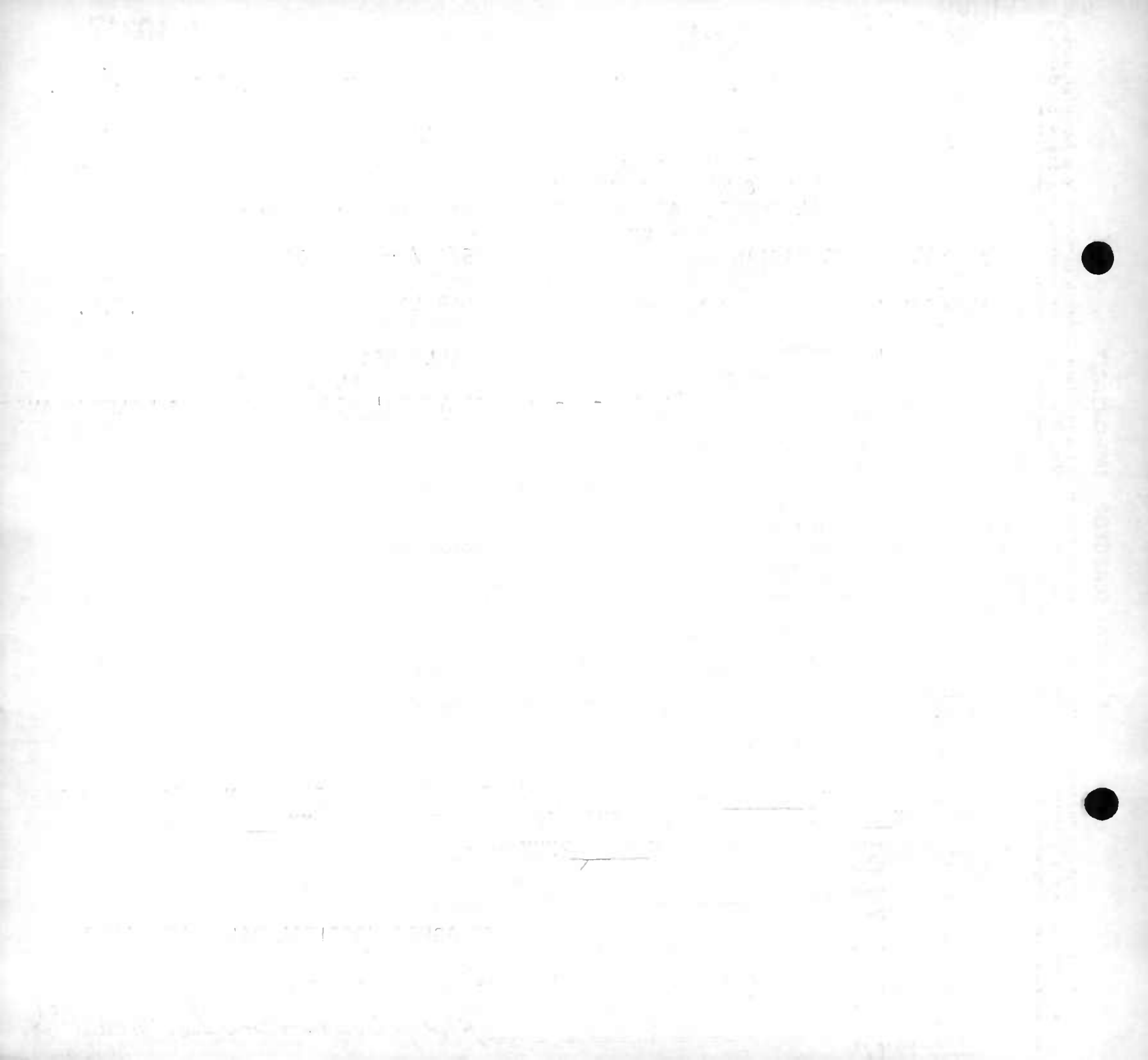
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 10246	
S-362 BIRTH NO.		71-10246 STRICKLAND					
1. NAME OF DECEASED (Type or Print) Strickland, Mattie				2. DATE AND HOUR OF DEATH 11/6/71 12:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland		B. COUNTY Baltimore	
				C. CITY OR TOWN Essex		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 1741 Earhart Road 21221			
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/90	9. AGE (In years last birthday) 81 yrs.	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) North Carolina		
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME B. Bess				14. MOTHER'S MAIDEN NAME Beaddie Baggett			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-54-0442		17. INFORMANT 4940 Eastern Avenue ADDRESS BCH RECORDS-Baltimore, Maryland			
18. CAUSE OF DEATH 441.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE Dissecting Aortic Aneurysm DUE TO, OR AS A CONSEQUENCE OF: (B) (R) CVA DUE TO, OR AS A CONSEQUENCE OF: (C) Shakes Epileptics		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 29 hrs 6 days 3 days	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/11/71 to 11/6/71 that (I) (we) last saw the deceased alive on 11/6/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Michael Pozen, MD				23B. DATE SIGNED 11/6/71		23C. PHYSICIAN'S NAME (Type) Michael Pozen, MD	
23D. ADDRESS Baltimore City Hospital 4940 Eastern Ave 21224							
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-8-71		24C. NAME of CEMETERY or CREMATORY Seven Mile Cemetery		24D. LOCATION (City, town, or county) (State) Samson County, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Jakes, M.D.		25C. FUNERAL DIRECTOR 1211 Chesaco Avenue			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

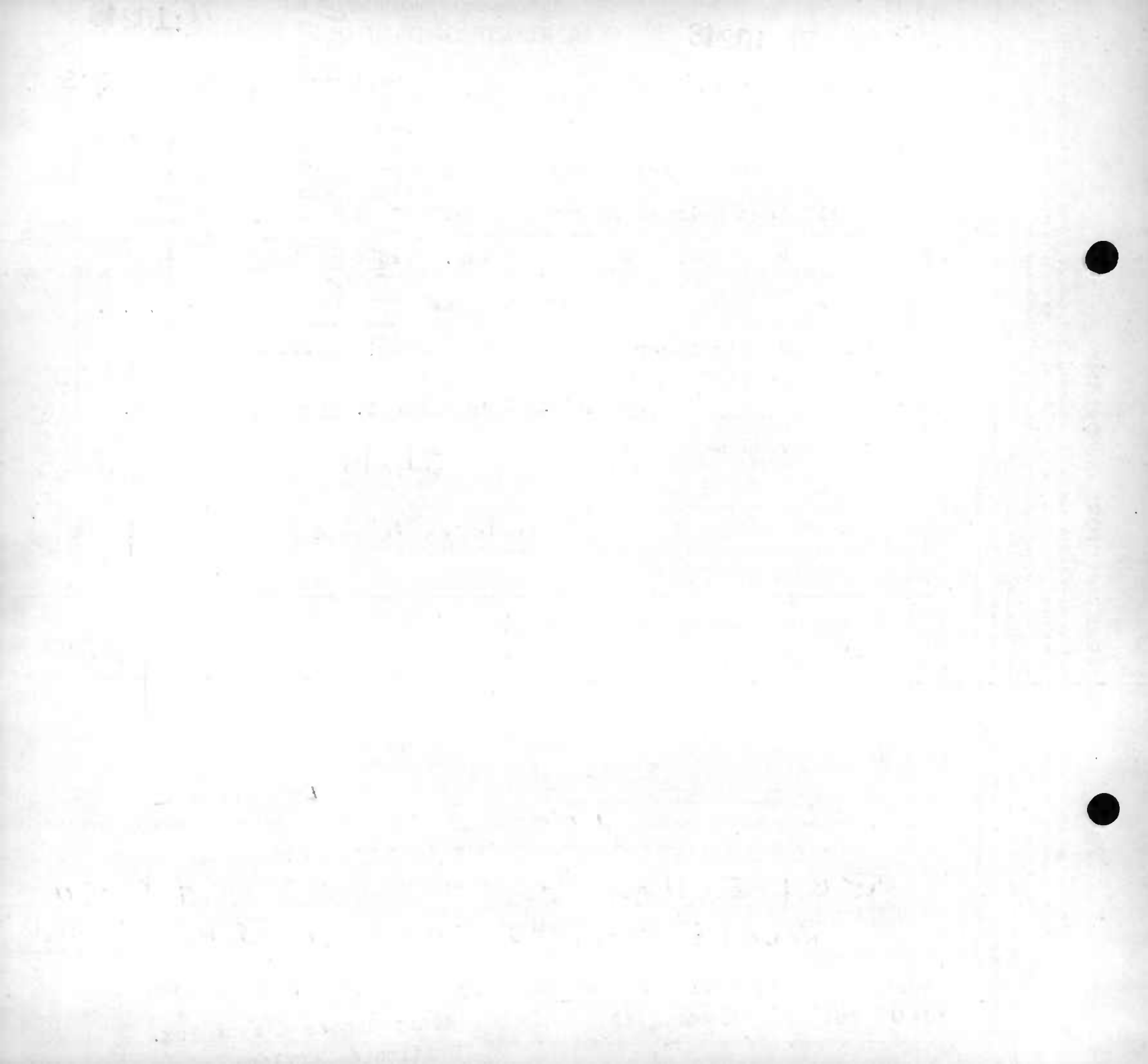
BIRTH NO. 71 10247				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10247	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
DREER, ALBERT HENRY				NOVEMBER 6, 1971		1:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
40		ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		MARYLAND ANNE ARUNDEL 21122			
5. SEX		6. RACE		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
MALE		CAUCASIAN		PASADENA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER			
				912 PIERPOINT DRIVE		5200	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MACHINIST		Koppers Co.		05/12/00		71	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
MARYLAND				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM DREER				SALLY BEARD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
YES		212-09-8466		BALTO MD 21229		ST AGNES' RECORDS CATON & WILKENS AVE S	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH							
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Anemia			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Secondary			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				to Nephrosclerosis.			
				(C)			
II				Old Myocardial Infarction.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (X) (this hospital) attended the deceased from OCTOBER 14 1971 to NOVEMBER 6 1971 that (IX) (we) last saw the deceased alive on NOVEMBER 6 1971 and that (in X) (our) applan death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
A. RAHMAN				November 6, 1971			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
A. RAHMAN				ST AGNES HOSPITAL BALTO MD 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11/9/71		London Park Cem.		Baltimore Md.	
25A. DATE REC'D. BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 8 1971		V. J. ...		John J. ... & Son Inc.		901 Hollins St. 23. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10248	
<div style="display: flex; justify-content: space-between;"> M-624 71 10248 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) LETA MAE MARSHALL			2. DATE AND HOUR OF DEATH NOVEMBER 4, 1971 3:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2712		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green Nursing Home			C. CITY OR TOWN BALTIMORE 21212		
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			E. STREET AND NUMBER 5313 St Albans Way		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1886	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Holland Flickinger		
14. MOTHER'S MAIDEN NAME Jennie Crawford			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 485-22-81220			17. INFORMANT Mr Clyde T. Marshall		
ADDRESS way 5313 St. Albans			18. CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Stroke			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Arteriosclerosis			(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). None			19A. DATE OF OPERATION 0		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 1968 to death 19 71 and that in (my) (our) opinion death occurred on the date 1 Nov 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Robert E. Mason MD			23B. DATE SIGNED 4 Nov '71		
23C. PHYSICIAN'S NAME (Type) Robert E. Mason MD			23D. ADDRESS 9 E Chase Balto Md		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/6/71	24C. NAME OF CEMETERY or CREMATORY Oakwood Cemetery	24D. LOCATION (City, town, or county) (State) Independence Iowa		
25A. FUNERAL DIRECTOR Henry Sander & sons Inc.			ADDRESS Baltimore Maryland		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-640				BALTIMORE CITY HEALTH DEPARTMENT		71 10249	
Greeley				CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Greeley, Elsie Mae</u>				2. DATE AND HOUR OF DEATH <u>11-3-71</u> <u>5:55 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Baltimore, MD</u> B. COUNTY <u>1338</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital of Baltimore Inc</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Belvidere Ave. at Gumpshy</u>		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-23-1891</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		9. AGE (in years last birthday) <u>80</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George Filmore Frock</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Wenzel</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212 05 0941</u>		17. INFORMANT <u>Sophia Mallowee</u>		ADDRESS <u>3628 Parkdale Ave</u>	
18. CAUSE OF DEATH <u>2309 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE <u>E.V.A.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>DM</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>							
19A. DATE OF OPERATION <u>○</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9-16-1971</u> to <u>11-3-1971</u> that (I) (we) last saw the deceased alive on <u>11-3-1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Lisark Boonsue, M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11-3-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>SRISOOK BOONSUE MD</u>				23D. ADDRESS <u>Sinai Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6 Nov 71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Sater's Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Brooklynville Balto Co Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Burgee Funeral Home</u>		ADDRESS <u>Baltimore Maryland</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 10250
BIRTH NO. J-525		71 10250		
1. NAME OF DECEASED (Type or Print) GLADYS JOHNSON		2. DATE AND HOUR OF DEATH 11/3/71 10:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1 C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2606 MARYLAND AVE.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/28/10	9. AGE (In years last birthday) 61
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -		
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Smallwood		14. MOTHER'S MAIDEN NAME Martha Matilda Lambert		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-14-1021		
17. INFORMANT Mrs Doris Loats		ADDRESS 6001 Falls Rd		
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C) _____				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED YES		
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 11-3 (7:00 pm. 19 71 to 11-3 (10:45 pm) 19 71		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 11-3 (7:00 pm. 19 71 to 11-3 (10:45 pm) 19 71 that (I) (we) last saw the deceased alive on 11-3 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Beltraund, M.D.				23B. DATE SIGNED 11/3/71
23C. PHYSICIAN'S NAME (Type) JUAN A. BELTRAUND				23D. ADDRESS M 244
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8 Nov 71		
24C. NAME of CEMETERY or CREMATORY May's Chapel Cemetery		24D. LOCATION (City, town, or county) (State) Lutherville, Baltimore Co Maryland		
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Burgee		
25C. FUNERAL DIRECTOR Burgee		ADDRESS Baltimore Maryland		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

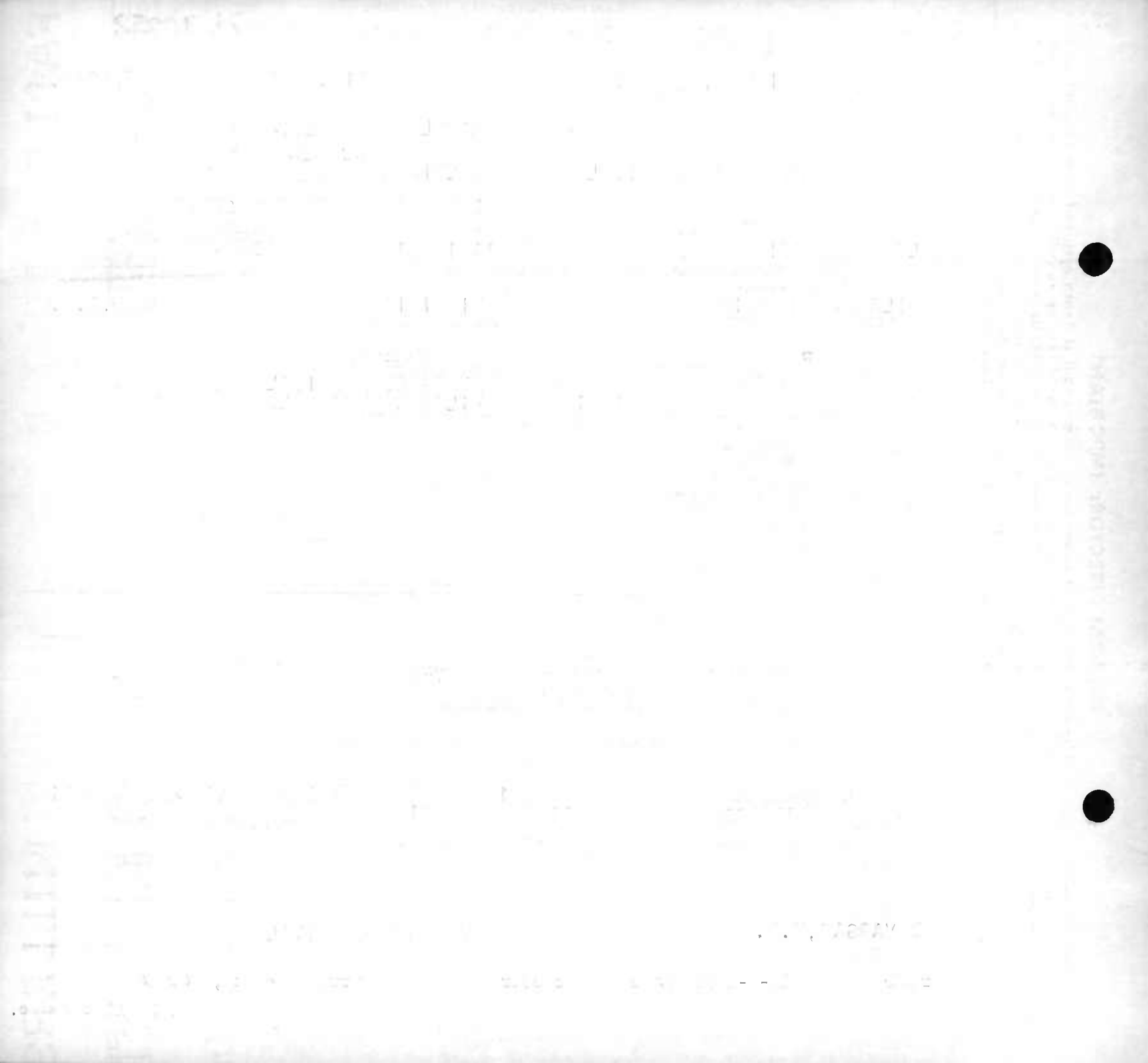
1. NAME OF DECEASED (Type or Print) CONSTANCE B. BOWEN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 714 N. Charles Rm. #910		3. DATE PRONOUNCED DEAD Month Day Year Hour November 3, 1971 2:10 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Balto. Co		6. SEX Female 7. RACE White 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 2-19-45 10. AGE (In years last birthday) 26 11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? USA 13. FATHER'S NAME Delbert Biersdorf	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Acc Clerk 14B. KIND OF BUSINESS OR INDUSTRY INSURANCE		15. MOTHER'S MAIDEN NAME Sarah King	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 218-52 3385 18. INFORMANT C.C. Bowen ADDRESS 1210 Brixton Rd	
19. E95091 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Overdose of meprobamate and acute ethylism		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hotel	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Sheraton Hotel-714 N. Charles St. Rm. 910		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 11-1 or 71 ? m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Took overdose and drank alcohol	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 4, 1971	
24A. BURIAL CREMATION, REMOVAL (Specify) cremation		24B. DATE 11-5-71 24C. NAME OF CEMETERY or CREMATORY Louisa	
24D. LOCATION (City, town, or county) (State) Balto. Md		25A. DATE REC'D BY HEALTH DEPT. NOV 8. 1971 25B. NAME OF REGISTRAR Robert S. Taylor, M.D.	
25C. FUNERAL DIRECTOR W.B. Bradley INC. Dundalk Md		ADDRESS	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO. 71 10252

C-625 BIRTH NO. 71 10252		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) CHRISMAN, ROBERT		2. DATE AND HOUR OF DEATH 11 04 71 6:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN HALETHORPE D. INSIDE CITY LIMITS XXXXXXXXXX YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1825 PARK AVENUE - 21227	
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 15 90
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOILER ROOM WORK		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 80 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218 18 5047	
17. INFORMANT ST AGNES HOSPITAL RECORDS CATON & WILKENS AVES BALTO MD 21229		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (B) Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 10 29 19 71 to 11 04 19 71 that (I) (we) last saw the deceased alive on 11 04 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (d) (s) (t) view the body after death.			
23A. SIGNATURE Enate A. Vargas Jr. M.D.		23B. DATE SIGNED 11-4-71	
23C. PHYSICIAN'S NAME (Type) D VARGAS, M.D.		23D. ADDRESS ST AGNES HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-6-1971	
24C. NAME of CEMETERY or CREMATORY Lakeview Cemetery		24D. LOCATION (City, town, or county) (State) Carroll County, Maryland	
25A. DATE REG'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Gaber, M.D.	
25C. FUNERAL DIRECTOR Howard A. Humbard Jr.		25D. ADDRESS 4107 Wilkens Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

71 10253

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Roy Lantz

2. DATE AND HOUR OF DEATH

11-4-71

2:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 212 24

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE

B. COUNTY

Maryland, Baltimore

C. CITY OR TOWN

Essex

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

1004 N. Marlyn Ave. 21221 005

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1-31-18

9. AGE (in years
last birthday)

53

If Under 1 Tr. Months Days Hours Mln.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Bricklayer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Roy K. Lantz

14. MOTHER'S MAIDEN NAME

XXXXXXXXXX

Mirrie (Unknown)

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W W II

16. SOCIAL
SECURITY NO.

17. INFORMANT

4940 Eastern Avenue

BCH-Records Baltimore, Maryland 21224

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) Disseminated pancreatic Ca.

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-4-71 to 11-4-71
that (I) (we) last saw the deceased alive on 11-4-71 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Loyal Leibrock

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

11/4/71

23C. PHYSICIAN'S
NAME (Type)

Loyal Leibrock

23D. ADDRESS

BCH 4940 Eastern Avenue
Baltimore, Md. 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11-8-1971

24C. NAME of CEMETERY or CREMATORY

Beverly Hills Mem. Gardens

24D. LOCATION

(City, town, or county)

(State)

Morgantown, West Virginia

25A. DATE REC'D BY HEALTH DEPT.

NOV 8 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

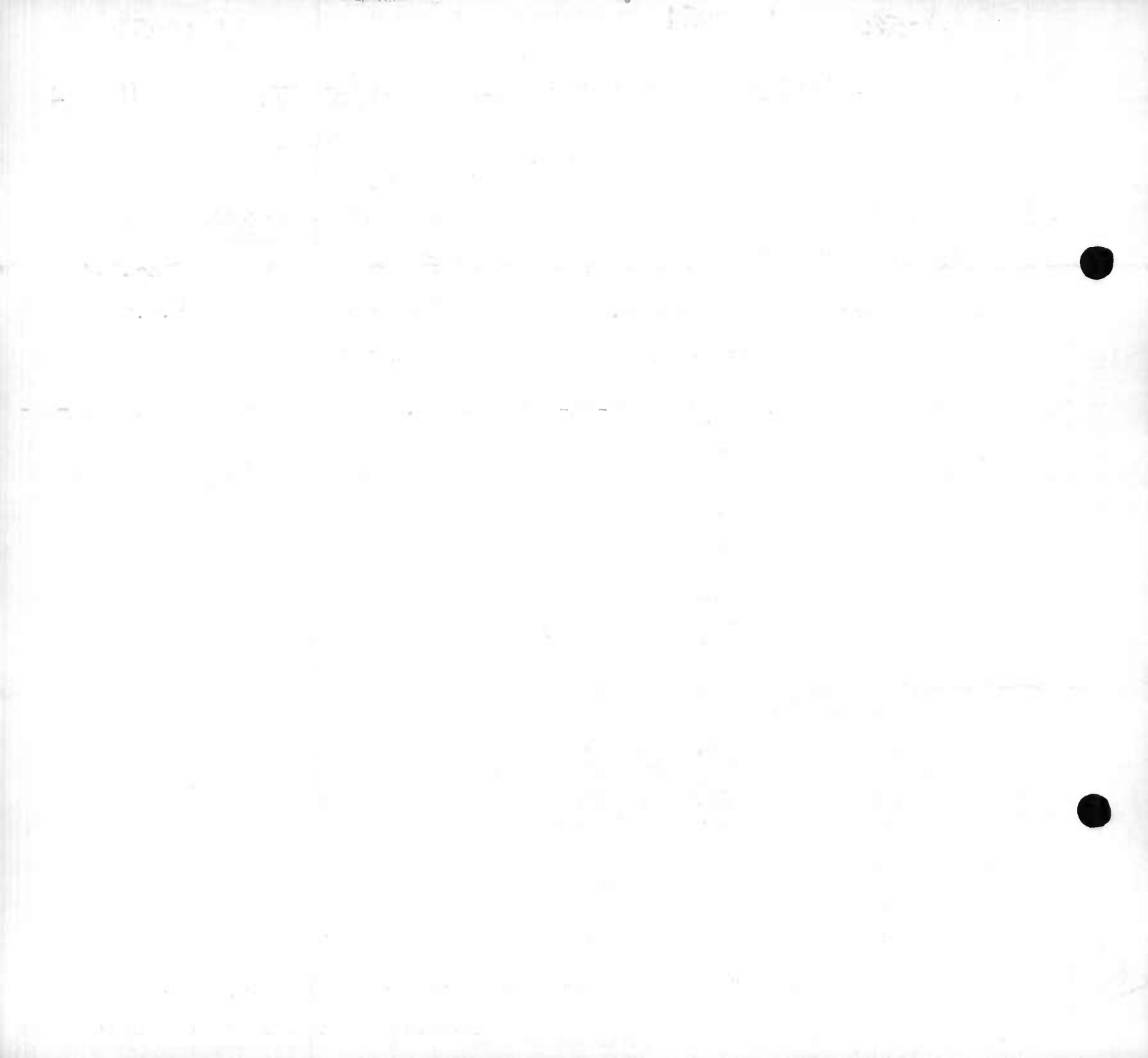
ADDRESS

Howard H. Hubbard, 4107 Wilkens Ave. 21229



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-520 71 10254		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10254	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JONES ELLSWORTH A.		2. DATE AND HOUR OF DEATH 11/5/71 11 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTO.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALTO. C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 836 WELLINGTON ST #21211			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/15/06	9. AGE (In years last birthday) 65	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY Constr.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Jones		14. MOTHER'S MAIDEN NAME Childs	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 553-01-2316		17. INFORMANT Anne G. Jones 836 Wellington St. -11-	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 291.04-250.9 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). DIABETES MELLITUS		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: DELIRIUM TREMENS (B) CHRONIC ALCOHOLISM (C) SEVERAL YEARS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nally medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/4 1971 to 11/5 1971 that (I) (we) last saw the deceased alive on 11/5 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE DAVID GLASER M.D.		23B. DATE SIGNED 11/5/71		23C. PHYSICIAN'S NAME (Type) DAVID GLASER M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/8/71		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Donovan Funeral Home		25D. ADDRESS 3818 Roland Ave			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

U-630		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10255	
BIRTH NO. 71 10255		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) URDEA, MARIA		2. DATE AND HOUR OF DEATH 11/3/71 10 ²⁰ A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSP 21224 4940 Eastern Avenue, Baltimore, Md.		A. STATE MD		B. COUNTY 2607	
		C. CITY OR TOWN BALT		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 342 S. OLD HAMS ST.			
5. SEX Female	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/13/87	9. AGE (In years last birthday) 84	10. Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) RUMANIA	
12. CITIZEN OF WHAT COUNTRY? RUMANIA		13. FATHER'S NAME JACOB NOARA		14. MOTHER'S MAIDEN NAME PEUNA CERBU	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-24-0531		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Ave., 21224	
18. 486 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH R/O PULMONARY EMBOLUS		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) PNEUMONIA			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4 ³⁰ Nov. 2 1971 to 10 ²⁰ Nov. 3 1971 that (I) (we) last saw the deceased alive on Nov. 3 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert J. Petrokubi		23B. DATE SIGNED 11/3/71			
23C. PHYSICIAN'S NAME (Type) Robert J. Petrokubi		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave., Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/6/71		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN	
24D. LOCATION BALTO. MD.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert J. Petrokubi, M.D.		25C. FUNERAL DIRECTOR J.G. CORNELLY SONS	
25D. ADDRESS 300 MACH					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 10256	
L-250 BIRTH NO. 71-19114-10256				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Lawson, Baby Boy</u>				2. DATE AND HOUR OF DEATH <u>11/5/71</u> <u>4:25</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 Mercy Hospital Inc.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Dundalk</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>2011 Duneen Drive. # 21222.</u>			
5. SEX <u>Male</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-2-71</u>		9. AGE (in years last birthday)	10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cecil Avery Lawson</u>				14. MOTHER'S MAIDEN NAME <u>Theresa Parsons</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Cecil A. Lawson</u>		ADDRESS <u>Same.</u>	
18. <u>776.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Ante respiratory Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Respiratory Distress Syndrome</u> <u>Prematurity</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11/21</u> 19 <u>71</u> to <u>11/5</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11/5</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>11/5/71</u>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-6-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>7225 Eastern Blvd., Balto. Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1971</u>		25B. NAME OF REGISTRAR <u>Robert A. Sader, M.D.</u>		25C. FUNERAL DIRECTOR <u>Charles S. Geiler</u>		ADDRESS <u>6224 Eastern Ave. Balto., 21224, Md.</u>	

CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

S Hook. Ruth.

Ruth E. Shook

2. DATE AND HOUR OF DEATH

11-4-71 -

16:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

808 S Ponca St. Baltimore, Md. 007

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

Dec. 10, 1898

9. AGE (in years
last birthday)

72

11 Under 1 Yr.
Months Days11 Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Waitress

10B. KIND OF BUSINESS OR INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

G. W. Hoy

14. MOTHER'S MAIDEN NAME

Hannah ?

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

217-20-0470

17. INFORMANT

4940 Eastern Ave. ADDRESS

BCH Records: Baltimore, Md. 21224

18. 43191

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

10-21-71

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)☐21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME

(Month) (Day) (Year) (Hour)

OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-21-1971 to 11-4-1971
that (I) (we) last saw the deceased alive on 11-4-1971 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Hamid

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

11-4-71

23C. PHYSICIAN'S
NAME (Type)

HAMID. M. MEHDI ZADEH

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Ave, Baltimore, Md. 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5/8/71

24C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

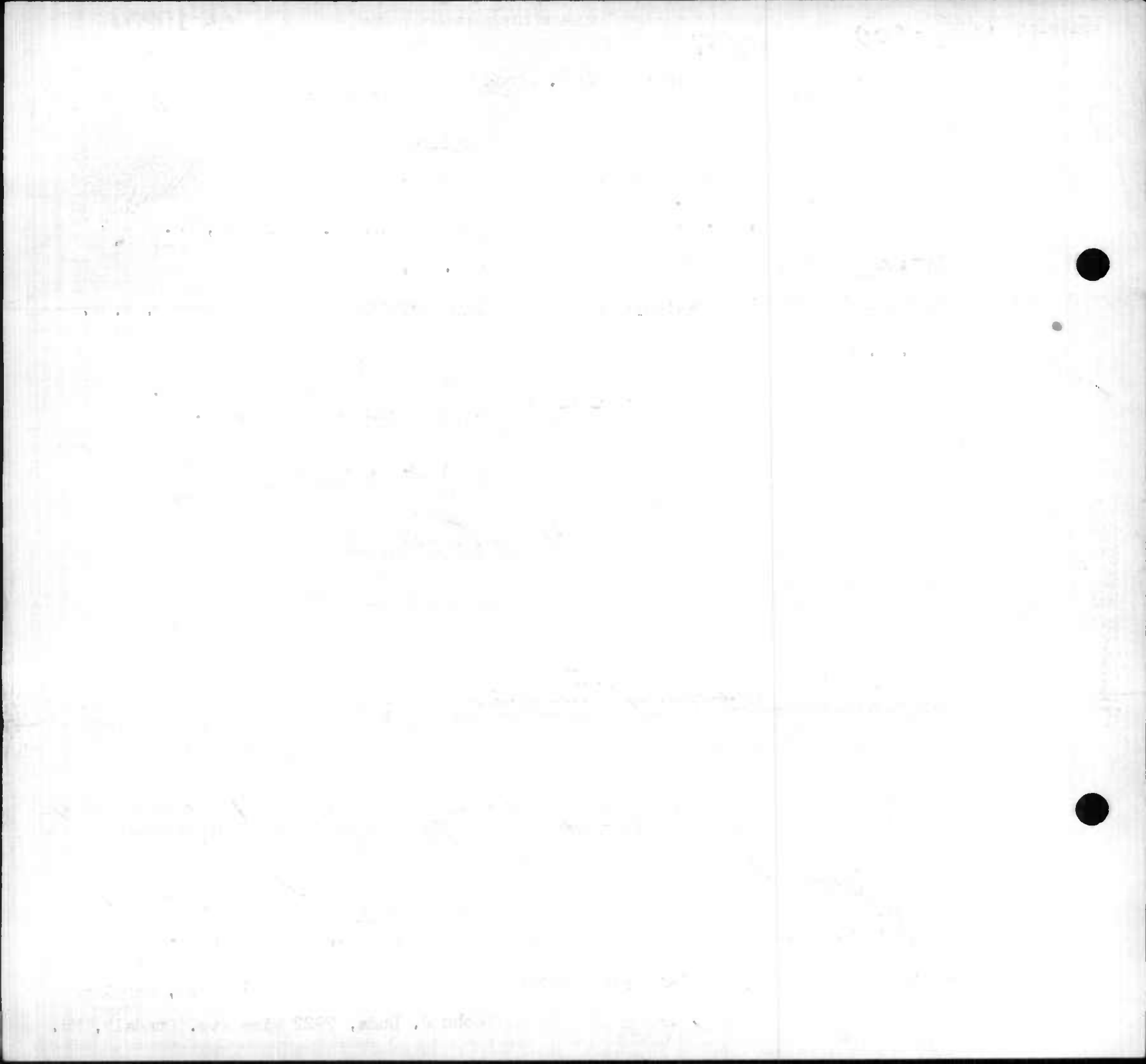
NOV 8 1971

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-600 71 10258		CITY HEALTH DEPARTMENT		71 10258	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) ERNA L. BAUER		2. DATE AND HOUR OF DEATH 11/5/71 12:30 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO			
FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL, BALTO, 37 MARYLAND.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6-23-17		9. AGE (In years last birthday) 54		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Penn.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Nathan Barefoot		14. MOTHER'S MAIDEN NAME Wyzatta Wright	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 194-09-2830		17. INFORMANT Medical Record	
18. 1579 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Pancreas (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION July 1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED obstructive jaundice		20A. AUTOPSY (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-9-71 to 11-5-71 that (I) (we) last saw the deceased alive on 11-5-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. C. Ugorji M.D.		23B. DATE SIGNED 11/5/71			
23C. PHYSICIAN'S NAME (Type) UGORJI M.D.		23D. ADDRESS Mercy Hosp, Balto, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-8-71		24C. NAME of CEMETERY or CREMATORY Gardens Of Faith Cemetery	
24D. LOCATION Overlea		24E. CITY, TOWN, OR COUNTY Balto.		24F. STATE Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Lassahn Funeral Home 7101 Belair Rd. Balto.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10259	
M-620 71 10259		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MARY MEYERS		2. DATE AND HOUR OF DEATH 11/5/71 9 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL 44		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4301 OVERHILL ROAD			
5. SEX FEM.	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/10/14	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME CHARLES SPRANKLE		14. MOTHER'S MAIDEN NAME EDITH MAE SPRANKLE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 276-28-3158		17. INFORMANT ADDRESS Hospital records	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PNEUMONIA (B) CEREBRO VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WK. 2 WEEKS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). GI. BLEEDING DUE PROBABLY TO STRESS ULCER.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/24 19 71 to 11/5 19 71 that (I) (we) last saw the deceased alive on 11/4 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ramon Del Bosto		23B. DATE SIGNED 11/5/71			
23C. PHYSICIAN'S NAME (Type) RAMON DEL BOSTO MD		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/9/71		24C. NAME OF CEMETERY or CREMATORY Tyrone Cem	
24D. LOCATION (City, town, or county) Tyrone Penn		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS C.F. EVANS & SON 8802 Harford road	

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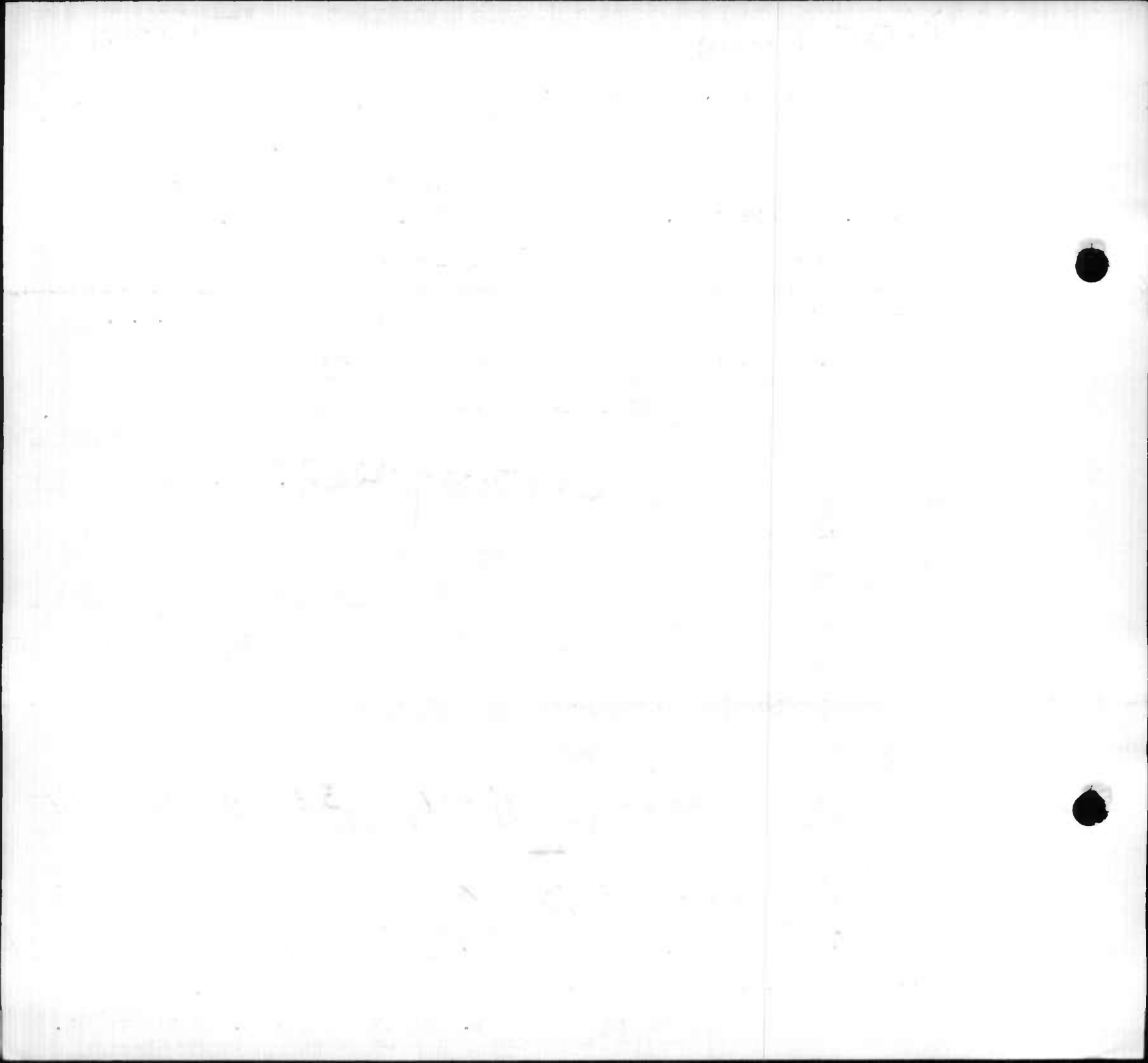
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

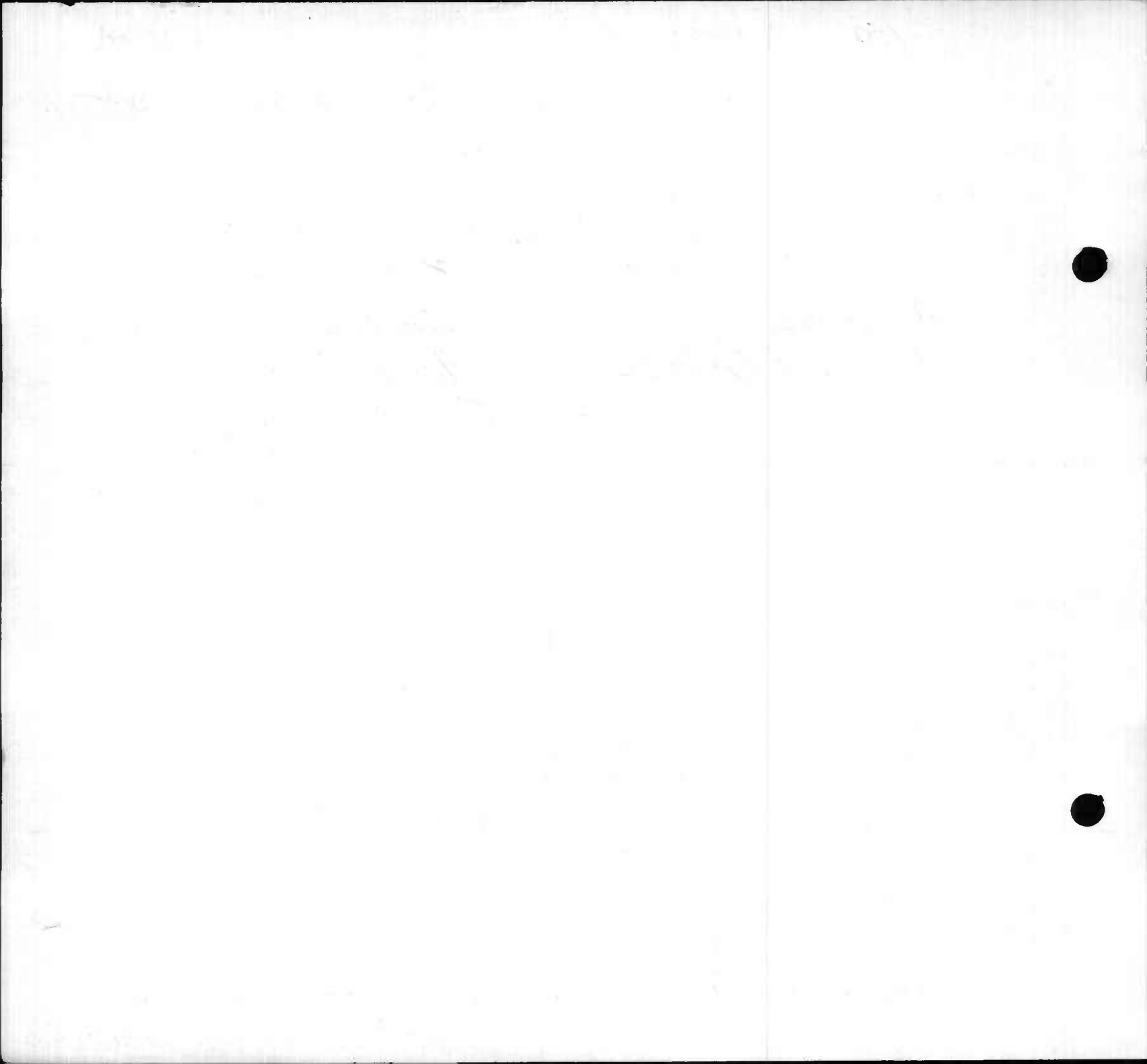
BIRTH NO. D-545 71 10260		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 10260	
1. NAME OF DECEASED (Type or Print) Marie R. Deinlein			2. DATE AND HOUR OF DEATH 11-3-71 1/45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2807 E. Jefferson St.			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Balto. C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2807 E. Jefferson St.		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-1900	9. AGE (In years last birthday) 71	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George P. Deinlein			14. MOTHER'S MAIDEN NAME Elizabeth Staab		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-48-8135		17. INFORMANT ADDRESS Margaret Deinlein 2807 Jefferson St.	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Primary heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia Terminal 24 hrs (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
19A. DATE OF OPERATION 11-3-71			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-3-71 to 11-3-71 that (I) (we) last saw the deceased alive on 11-3-71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. J. Mendel			23B. DATE SIGNED 11-3-71		23C. PHYSICIAN'S NAME (Type) C. J. Mendel
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 11-6-71		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971			25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS B. Dabrowski 2818 E. Baltimore St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

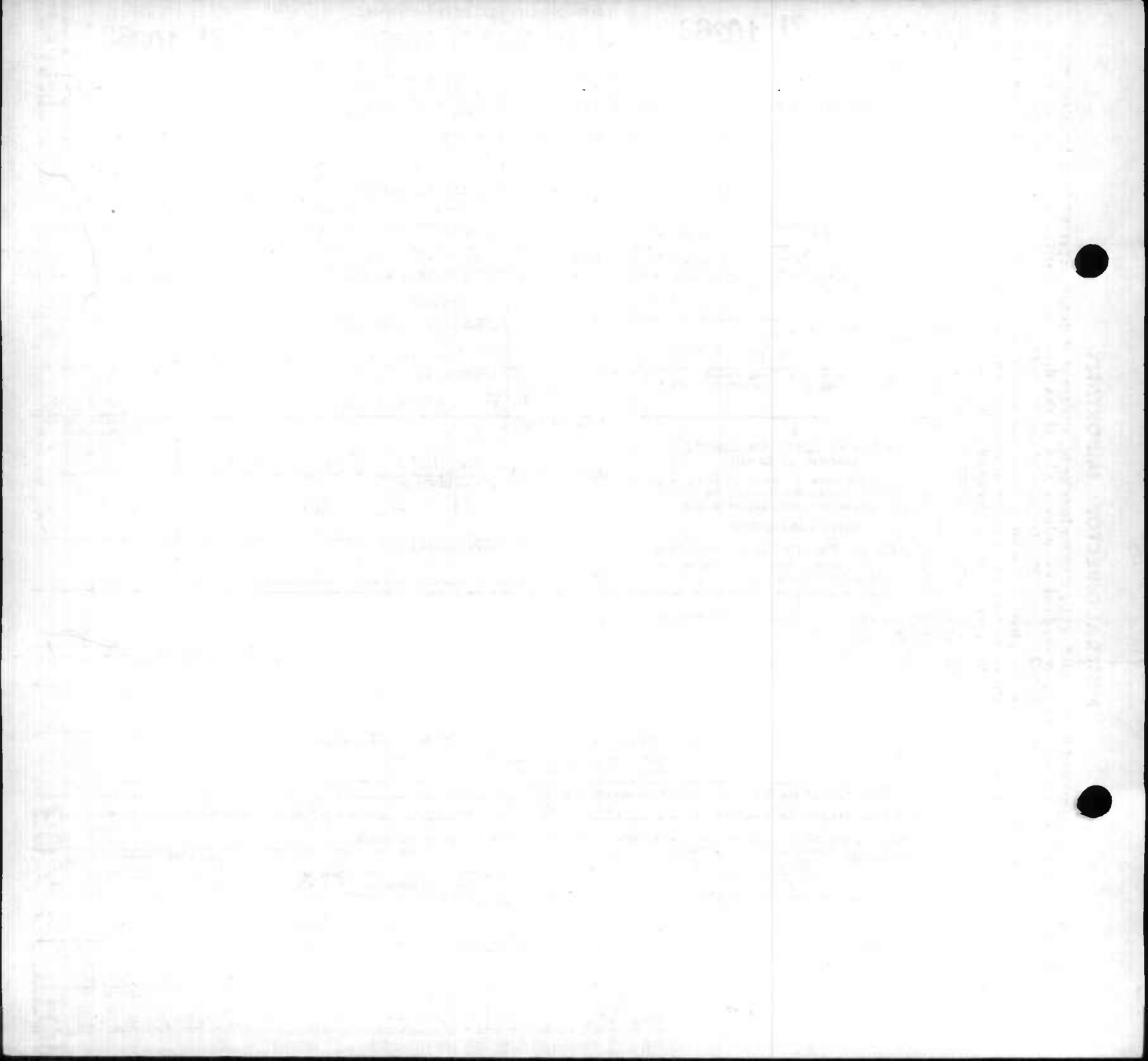
F-450 71 10261		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 10261	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) KILLIAN, CAROLINE M.		2. DATE AND HOUR OF DEATH Nov. 3, 1971 1:54 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO		5. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 9 WEDGEWOOD NURSING HOME		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/12/29	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 92	
13. FATHER'S NAME Herman F. Radecke		14. MOTHER'S MAIDEN NAME Mary Meyer		11. BIRTHPLACE (State or foreign country) Baltimore	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. INFORMANT F. Vernon Letmate		ADDRESS - 3603			
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Landbeck Rd		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (1) Arterio Sclerotic Heart Disease		5 yrs	
		(B) (2) Bilateral Broncho - Pneumonia		- 3 days	
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Chronic Brain Syndrome			
19A. DATE OF OPERATION Home		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct. 29 19 71 to Nov. 3 19 71 that (I) was last saw the deceased alive on Nov. 3 19 71 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) was (did) view the body after death.					
23A. SIGNATURE Earl L. Chambers M.D.		23B. DATE SIGNED 11/5/71		23C. PHYSICIAN'S NAME (Type) Earl L. Chambers - M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-6-71		24C. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ARMACOST FUNERAL CHAPL - 4601 Lib. Hgts Ave	
				ADDRESS BALTIMORE, MD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 10262</u>	
<div style="display: flex; justify-content: space-between;"> M-320 71 10262 CERTIFICATE OF DEATH </div>					
BIRTH NO. _____					
1. NAME OF DECEASED (Type or Print) <u>Matthews, BEATRICE ELIZABETH</u>			2. DATE AND HOUR OF DEATH <u>Nov. 5, 1971 8 AM</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>SOUTH BALTIMORE GENERAL HOSPITAL</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>GLEN BURNIE</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>GLEN BURNIE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<u>43</u>			E. STREET AND NUMBER <u>RT 1 Box 211 A Glen Burnie Md. 21061</u>		
5. SEX <u>♀</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-16</u>	9. AGE (in years last birthday) <u>55</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
<u>Eastern Products</u>			<u>Tennese</u>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
			<u>USA</u>		
13. FATHER'S NAME <u>JAMES CAMPBELL</u>			14. MOTHER'S MAIDEN NAME <u>REBECCA CLEMENTS</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>409-28-0688</u>		
			17. INFORMANT <u>AMASA L. (HUSBAND)</u> ADDRESS <u>SAME</u>		
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOGENIC CARCINOMA</u> OF THE LUNG			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on <u>Nov. 4</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ho Jin Bae</u>				23B. DATE SIGNED <u>11-5-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>HO JIN BAE, MD.</u>				23D. ADDRESS <u>South Baltimore General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/8/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Ritchie Hwy Glen Burnie Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Valley, M.D.</u>	
25C. FUNERAL DIRECTOR <u>McCully Funeral Home</u>		25D. ADDRESS <u>237 Patapsco Ave</u>			



FUNERAL DIRECTOR: IMPORTANT

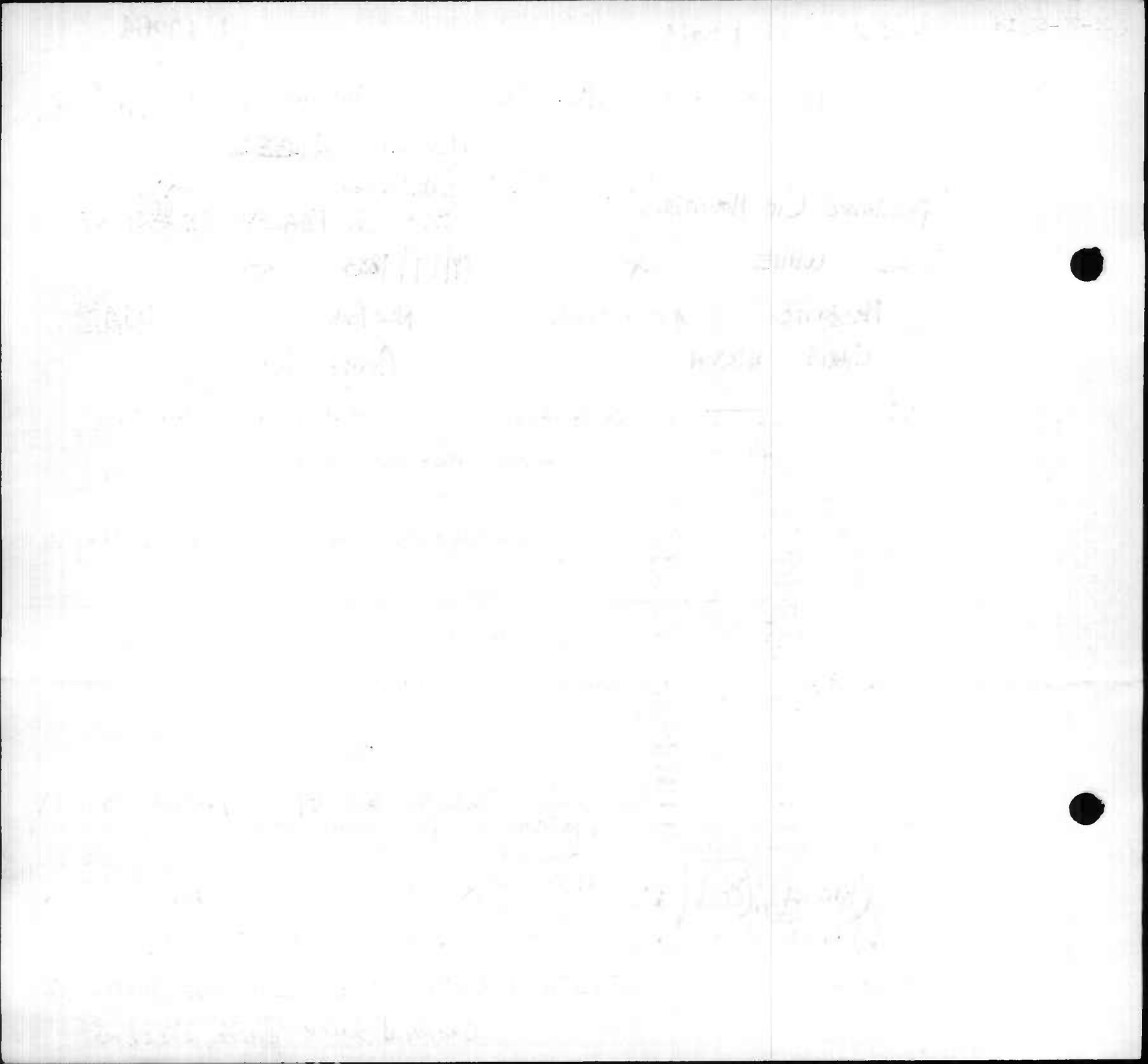
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10263	
CERTIFICATE OF DEATH					
BIRTH NO. T-416 71 10263		1. NAME OF DECEASED (Type or Print) Tollberg VALERIE Z TOLLBERG		2. DATE AND HOUR OF DEATH 11-4-71 5:17 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2544 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Soo Jeffery St.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-16-19	9. AGE (In years last birthday) 52 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Security Office Massachusetts
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Security Office Massachusetts			10B. KIND OF BUSINESS OR INDUSTRY Social Security Office Massachusetts		11. BIRTHPLACE (State or foreign country) USA
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 026 16 8098		17. INFORMANT Daughter - Wiskin Marianowski	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiogenic shock (B) Acute myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 	
22. I certify that (I) (this hospital) attended the deceased from 11-2 19 71 to 11-4 19 71 that (I) (we) last saw the deceased alive on 11-4 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Virginia Lewis - Mercado M.D.				23B. DATE SIGNED 11-4-71	
23C. PHYSICIAN'S NAME (Type) VIRGINIA F. MERCADO, M.D.				23D. ADDRESS South Baltimore General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/6/71		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	
24D. LOCATION (City, town, or county) (State) Ritchie Hwy Glen Burnie		25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971			
25B. NAME OF REGISTRAR Robert E. Kelly, Jr.				25C. FUNERAL DIRECTOR McCully Funeral Home 237 Patapsco	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-120		71 10264		BALTIMORE CITY HEALTH DEPARTMENT		71 10264	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ANNA M. DEVAUX				2. DATE AND HOUR OF DEATH November 3, 1971 10 ¹⁵ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS (4940 Eastern Ave, Balto, Md 21224)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 813 S. FAGLEY ST. #21224.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/1883	9. AGE (In years last birthday) 88	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) New York
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY AT HOME.		12. CITIZEN OF WHAT COUNTRY? USA.		
13. FATHER'S NAME CHRIS NELSON				14. MOTHER'S MAIDEN NAME ANNA MARIE ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-26-1586		17. INFORMANT 4940 Eastern Avenue BCH RECORDS - Baltimore, Maryland 21224			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CARCINOMA OF BREAST				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 4 years 3 years			
19A. DATE OF OPERATION 0 11/19/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca Breast		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from DECEMBER 5 1969 to November 3 1971 that (2) (we) last saw the deceased alive on November 3 1971 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard Reed for M.D.				23B. DATE SIGNED Nov. 3. 1971			
23C. PHYSICIAN'S NAME (Type) RICHARD REED for M.D.				23D. ADDRESS BALTIMORE CITY HOSPITALS.			
24A. BURIAL REMOVAL (Specify) BURIAL		24B. DATE 11-6-71		24C. NAME OF CEMETERY OR CREMATORY ST. PETER'S CEM.		24D. LOCATION (City, town, or county) (State) 1300 MORELAND AVE. BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Isabel E. Taylor, M.D.		25C. FUNERAL DIRECTOR Charles J. Taylor 901 S. CONKLING ST. BALTO., 21224, MD.			



REG. NO.

VS 151-REV. 7/1/68

N 869.0

2850E 15

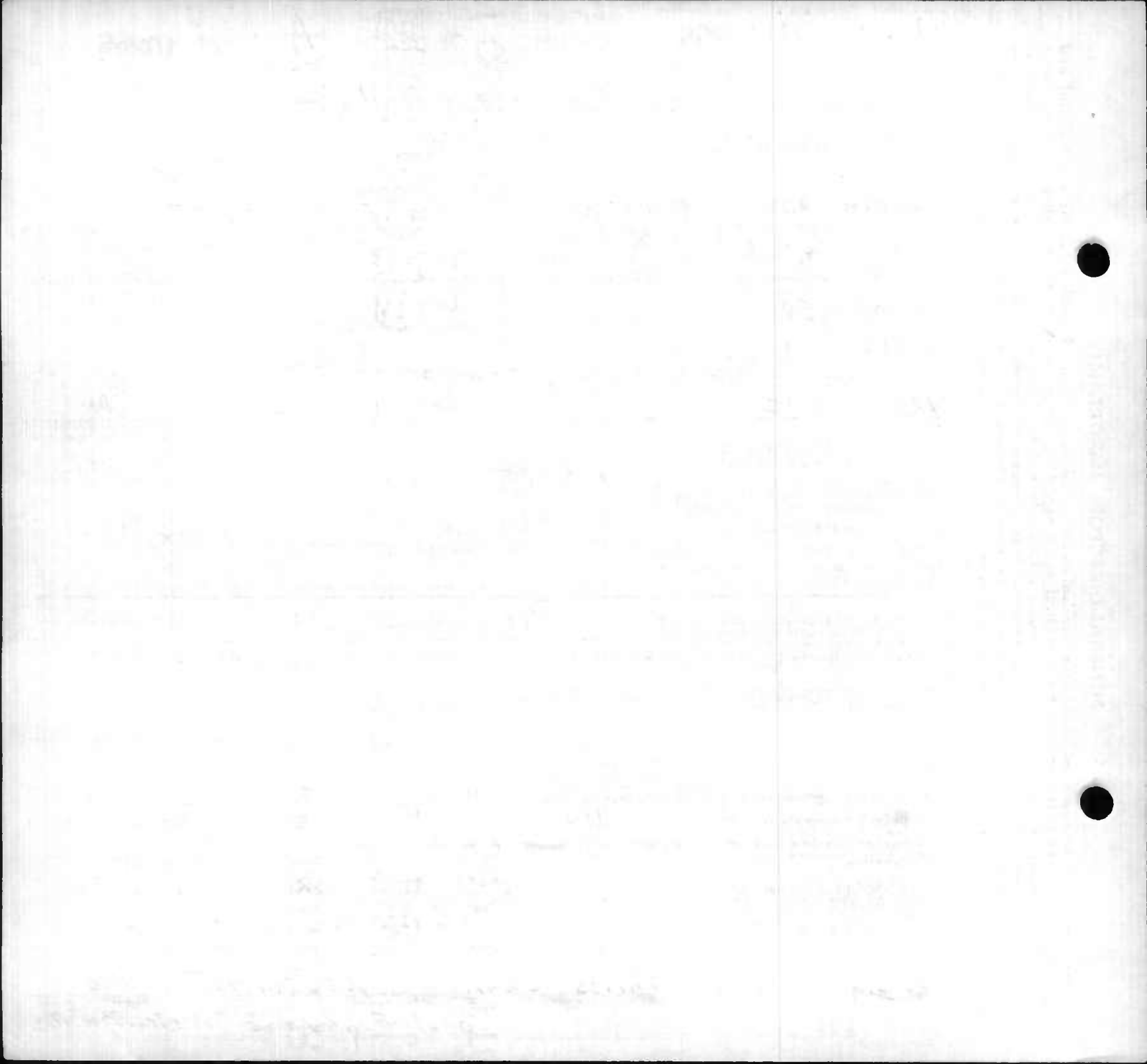
2850E 15



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

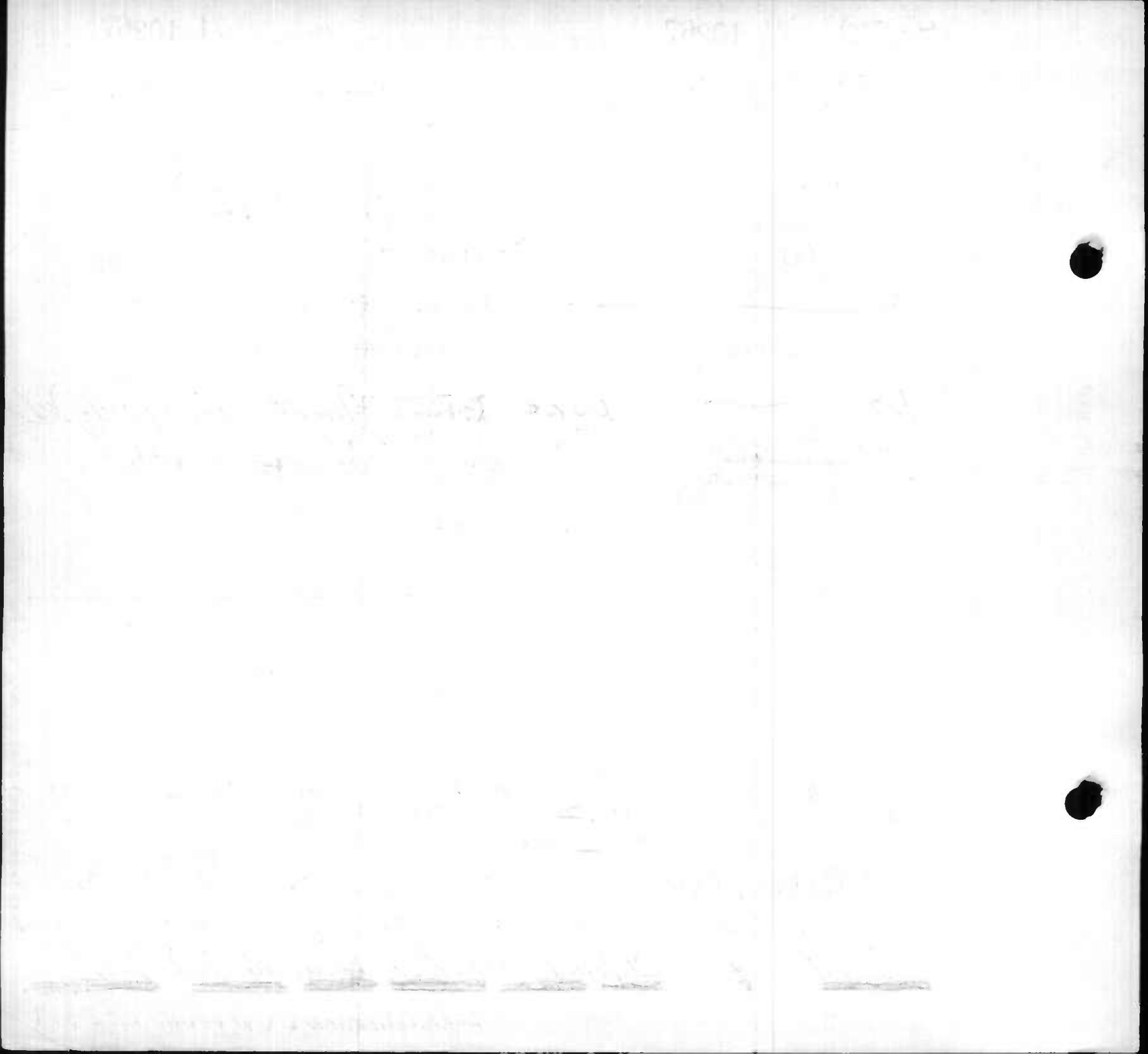
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10266	
W-415 71 10266		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CHARLES E. WILFONG		2. DATE AND HOUR OF DEATH 11/6/71 12:25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHURCH HOME & HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD. B. COUNTY 201 C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1929 E. BALTO. ST.	
5. SEX M	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-16
9. AGE (in years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED	
11. BIRTHPLACE (State or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OH LAND WILFONG		14. MOTHER'S MAIDEN NAME BENNETT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 236033869	
17. INFORMANT DAISEY WILFONG		ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 519.3 I Respiratory failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic obstructive lung disease (B) DUE TO, OR AS A CONSEQUENCE OF: Phenomenia, LLL (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months undetermined	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 10/20 19 71 to 11/6 19 71 that we (we) last saw the deceased alive on 11/6 19 71 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did not) view the body after death.			
23A. SIGNATURE Wm. A. Maniago, M.D.		23B. DATE SIGNED 11/6/71	
23C. PHYSICIAN'S NAME (Type) WILMA B. MANIAGO M.D.		23D. ADDRESS CHURCH HOME & HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-11-71	
24C. NAME of CEMETERY or CREMATORY Philas Cem.		24D. LOCATION (City, town, or county) (State) WESTERN PORT, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Boal Funeral Home, Western Port, Md.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

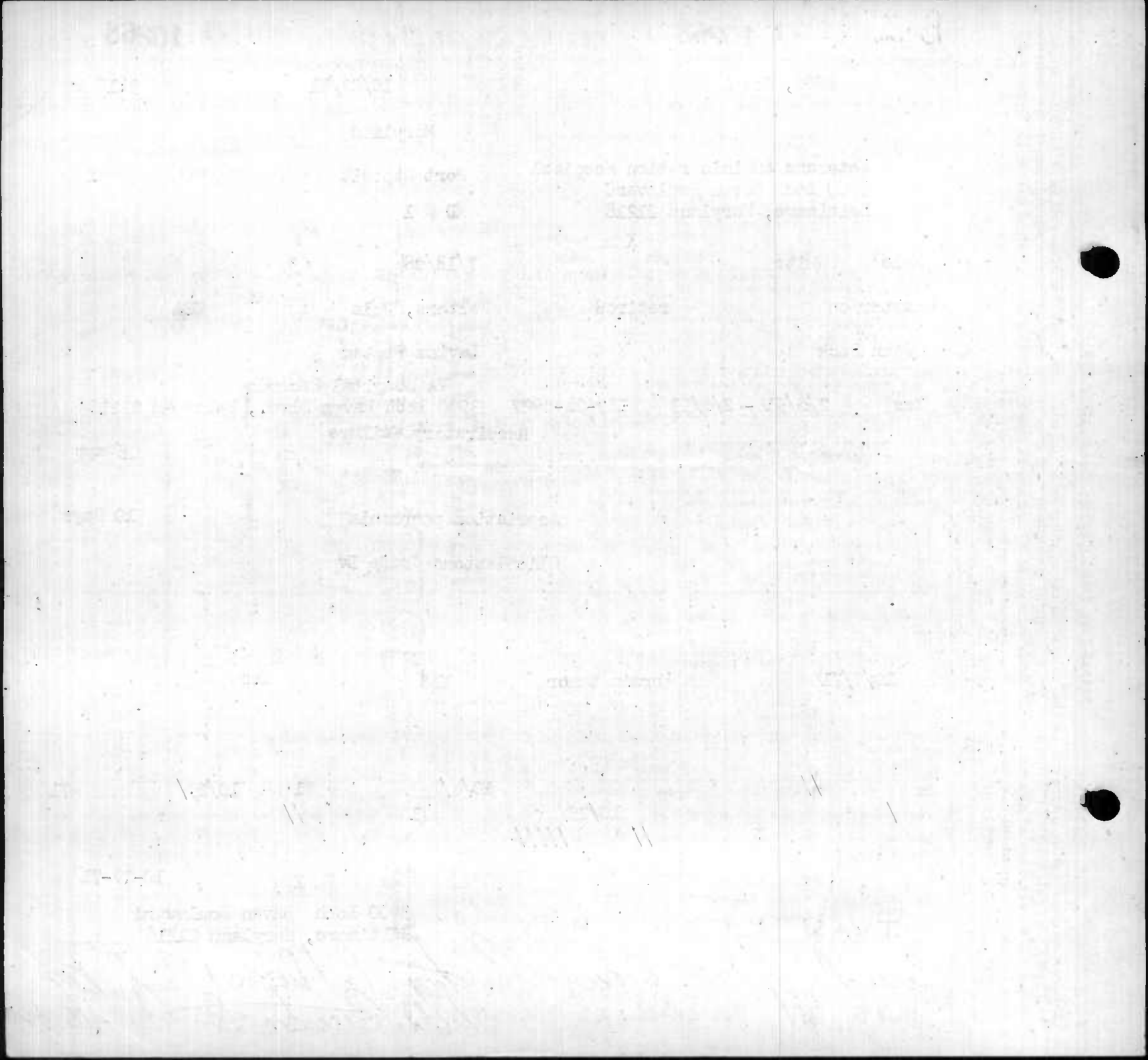
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 10267	
A-530 71 10267 BIRTH NO. Harre de Grace, Md.		2. DATE AND HOUR OF DEATH 11-2-71 10:10 A	
1. NAME OF DECEASED (Type or Print) Baby Boy Amato		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Cecil	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital 33		C. CITY OR TOWN Perryville D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-1-71 9. AGE (in years last birthday) 26	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Harre de Grace, Md	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Amato		14. MOTHER'S MAIDEN NAME Stephanie Weaver	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert Amato ADDRESS Perryville, Md		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Respiratory distress Syndrome, Probable renal agenesis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Prematurity (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 26 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that 11 (this hospital) attended the deceased from 11-1 19 71 to 11-2 19 71 that 11 (we) last saw the deceased alive on 11-2 19 71 and that in 11 (our) opinion death occurred on the date and hour and from the causes stated above. 11 (We) (did) (did not) view the body after death.			
23A. SIGNATURE R C Baker, M.D.		23B. DATE SIGNED 11-2-71	
23C. PHYSICIAN'S NAME (Type) Raymond C. Baker, M.D.		23D. ADDRESS 550 N. Broadway, Apt 306 Baltimore Md 21205	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 11/6/71	
24C. NAME OF CEMETERY OR CREMATORY St. Marks Cemetery		24D. LOCATION (City, town, or county) Perryville Cecil Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR LEE A. PATTERSON		ADDRESS 30 N. PERRYVILLE MD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-200 71 10268				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10268	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				BUCK, Joe L		10/29/71 3:15 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
Veterans Administration Hospital				Maryland		Cecil 5700	
3900 Loch Raven Boulevard				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Baltimore, Maryland 21218				Port Deposit		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX				6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male				White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH				9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
7/18/08				63		Quarterman	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Walters, Okla				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Buck				Lavina Tipton			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes 2/6/51 - 2/6/53				189-24-8927		VA Hospital Records 3900 Loch Raven Blvd., Balto Md 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				Respiratory failure			
19A. ANTECEDENT CAUSES				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				5 Days			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				10 Days			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
3 10/7/71				YES		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				brain tumor			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from 10/4/19 71 to 10/29/19 71							
that (we) last saw the deceased alive on 10/29/19 71 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
JUAN LORA M.D.						10-29-71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JUAN LORA M.D.				3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11/1/1971		Hopewell Cemetery		Port Deposit, Cecil, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 8 1971		Robert E. Fisher, M.D.		Hilda Lawson		Baltimore, Md	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MICHAEL LIPMAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 521 N. Charles St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 1 1971 10:50a M.	
6. SEX male		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Montgomery 6500	
9. DATE OF BIRTH Jan. 2, 1945		10. AGE (In years lost birthday) 26 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Esther Marcuson		13. FATHER'S NAME Eugene J. Lipman	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Eugene J. Lipman		ADDRESS Same as 5e	
19. CAUSE OF DEATH E 834.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Poisoning by overdose of Talwin (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 521 N. Charles St.		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 10-?-71 ?	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Developed addiction to Walwin.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11-1-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 3, 1971	
24C. NAME of CEMETERY or CREMATORY King David Memorial Garden		24D. LOCATION (City, town, or county) (State) Falls Church, Virginia	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Donald M. Stein Heb. Mem. Funeral H. St., N.W. Wash. D.C.		ADDRESS 232 Carroll	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>E-152</i>		71 10270		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <i>71 10270</i>	
1. NAME OF DECEASED (Type or Print) <i>ANNIE ELIZABETH EVANS</i>				2. DATE AND HOUR OF DEATH <i>SAT. NOV. 6, 1971 8:00 AM</i>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <i>0038 E. FORT AVE</i>				A. STATE <i>MARYLAND</i>		B. COUNTY <i>2302</i>		C. CITY OR TOWN <i>BALTIMORE</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>BALTIMORE, MD.</i>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>38 E. FORT AVENUE</i>			
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>MAY-19-1892</i>		9. AGE (In years last birthday) <i>79</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE-FUNERAL DIRECTOR-RE FUNERAL</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>THOMAS BURKE</i>				14. MOTHER'S MAIDEN NAME <i>MARY MOON</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO-</i>				16. SOCIAL SECURITY NO. <i>24-38-6432</i>		17. INFORMANT <i>CURTIS E. EVANS (SON)</i>		ADDRESS <i>1400 S. CHARLES ST. MD. 21230</i>	
18. <i>410.941250.9</i>				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic C.V. Dis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>many yrs</i>	
ANTECEDENT CAUSES				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Atherosclerosis -</i>		<i>years</i>	
						(C) <i>Coronary Occlusion</i>			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>Diabetes Mellitus</i>		<i>20 years</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>1968</i> to <i>11/6/71</i> and that (I) (we) last saw the deceased alive on <i>11/5/71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Walter Kohn</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>11/6/71</i>			
23C. PHYSICIAN'S NAME (Type) <i>WALTER KOHN MD</i>				23D. ADDRESS <i>102 E. FORT AVE BALTO, MD. 21230</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Nov. 9, 1971</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cedar Bell Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Brooklyn, D.C., Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1971</i>		25B. NAME OF REGISTRAR <i>Blaise E. Feltz, Jr.</i>		25C. FUNERAL DIRECTOR <i>CURTIS E. EVANS</i> ADDRESS <i>1400 S. CHARLES ST. BALTIMORE, MD. 21230</i>					

CERTIFICATE OF DEATH

REG. NO.

71 10271

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ESSIE L. HUGEE

2. DATE AND HOUR OF DEATH

November 6, 1971 7:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Baltimore City Hospital - Baltimore
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)

A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

1504 KENHILL AVENUE 21213

5. SEX

Female

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

7/18/1910

9. AGE (in years
last birthday)

61

10. Under 1 Yr. 11. Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Ben McWhite

14. MOTHER'S MAIDEN NAME

Mary Hunter

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

BCH RECORDS; 4940 Eastern Avenue
Baltimore, Maryland 21224APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH18. 412.291250.9
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIORESPIRATORY ARREST

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Multiple Cerebral-vascular accidents.

(C)

HYPERTENSIVE CARDIOVASCULAR DISEASE

(D)

DIABETES MELLITUS

(E)

ATHEROSCLEROTIC VASCULAR DISEASE

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPT? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (A) (this hospital) attended the deceased from SEP 3 19 71 to November 6 19 71
that (A) (we) lost saw the deceased alive on November 6 19 71 and that in (our) opinion death occurred on the date
and hour and from the causes stated above. (A) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard Reed M.D.
Richard R. Love M.D.23B. DATE SIGNED
SEP 6. 197123C. PHYSICIAN'S
NAME (Type)23D. ADDRESS
Baltimore City Hospitals.24A. BURIAL CREMATION
REMOVAL (Specify)

Burial

24B. DATE

11-12-71

24C. NAME OF CEMETERY or CREMATORY

Pamplico, S.C.

24D. LOCATION

(City, town, or county) (State)

25A. DATE RECD BY HEALTH DEPT.

NOV 8 1971

25B. NAME OF REGISTRAR

Wm C March

25C. FUNERAL DIRECTOR

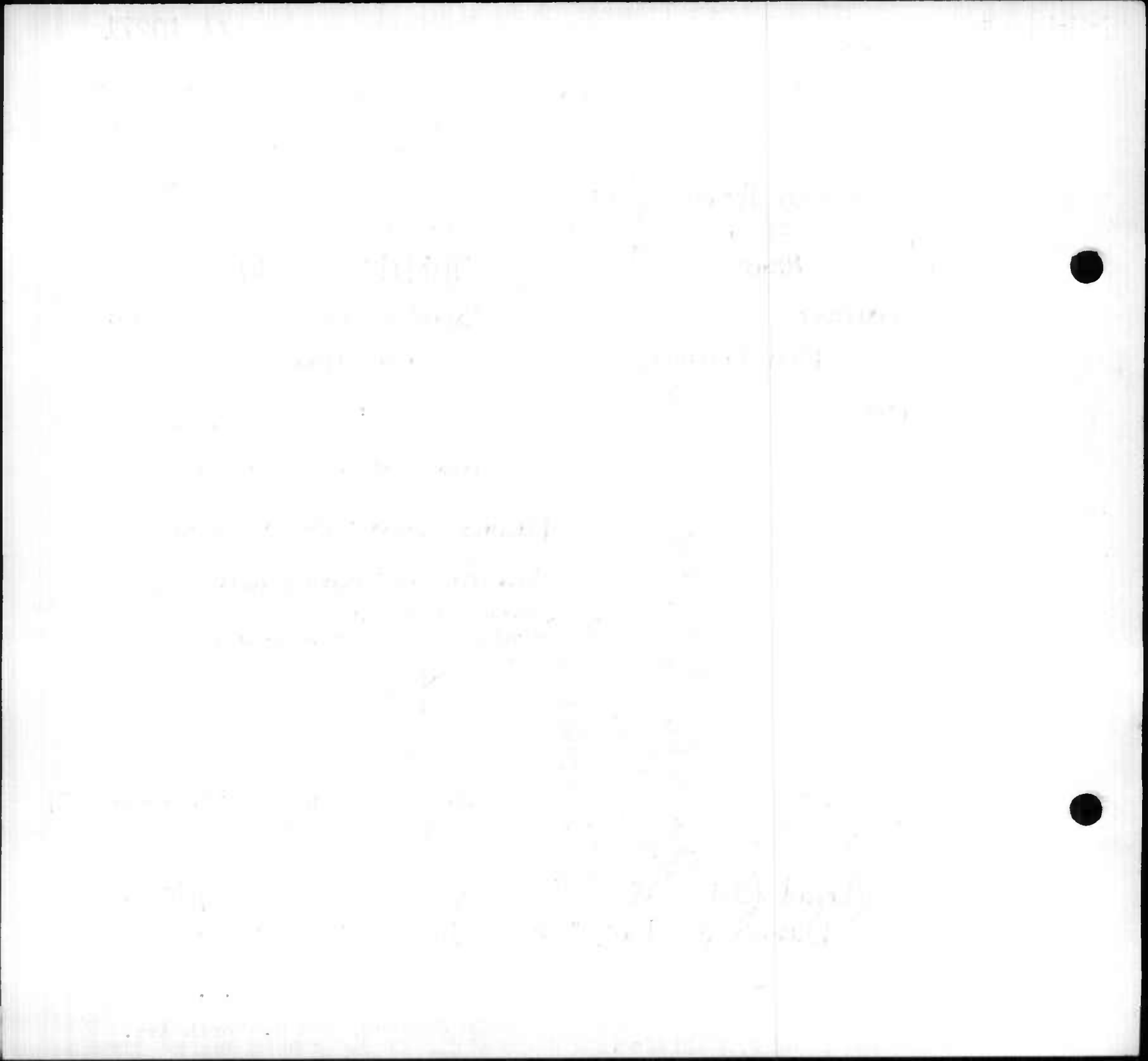
Wm C March

ADDRESS

928 E. North Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

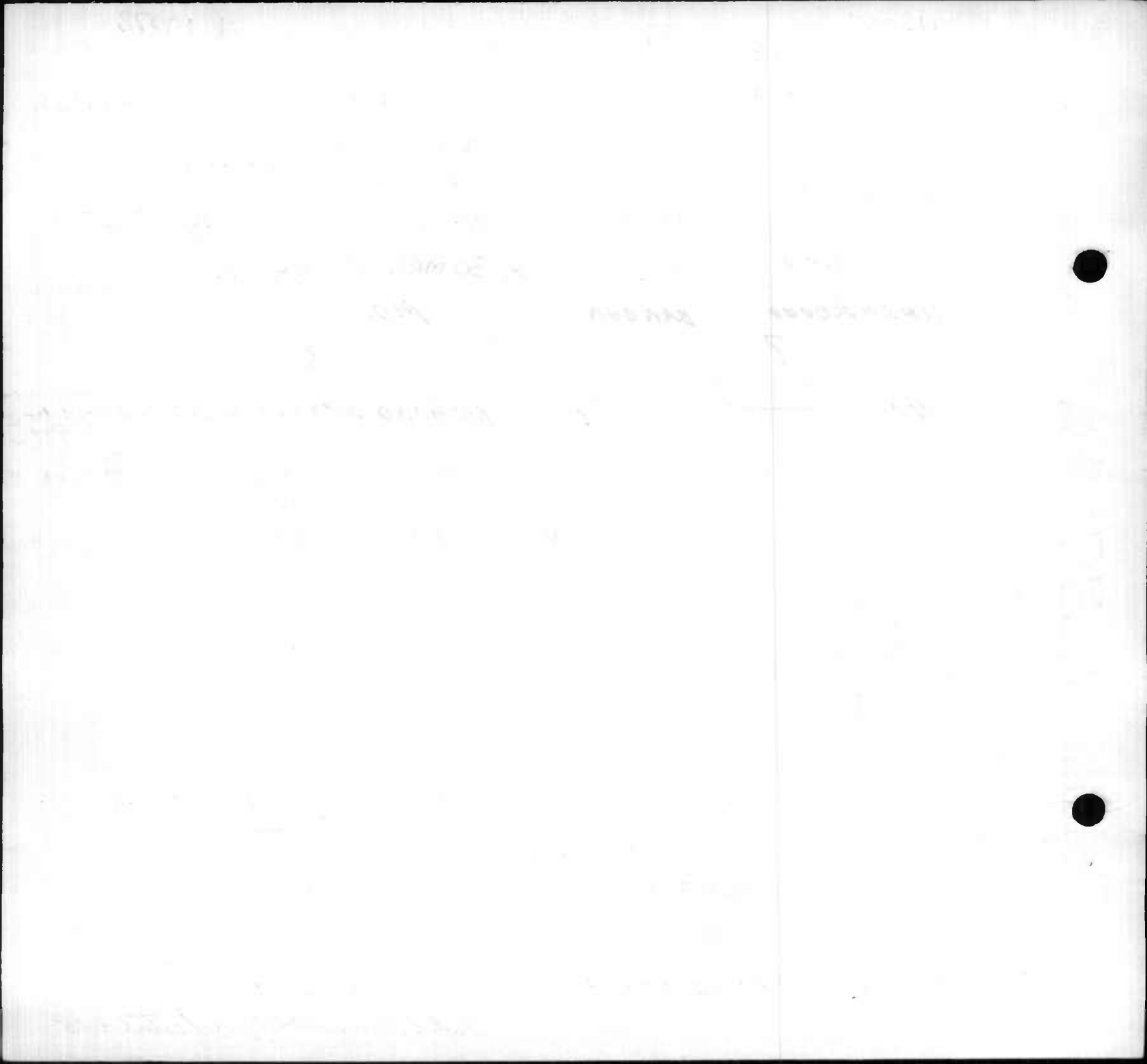
REG NO

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		LIONEL JOHNSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour		November 3, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital or institution, give street address or location)				3. DATE PRONOUNCED DEAD Month Day Year Hour			
Sinai Hospital (DOA)				November 3, 1971 1:30 P.M.			
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
						D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Dec 13-1946		10. AGE (in years last birthday) 25		11. BIRTHPLACE (State or foreign country) BALTO MD		12. CITIZEN OF WHAT COUNTRY? USA	
						13. FATHER'S NAME GUYSON JOHNSON	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME ESTHER SMITH			
Longshoreman Port of Baltimore							
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 212-46-7266		18. INFORMANT CORRADO JOHNSON 3017 Ridge Wood Dr			
19. 304.9		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE Intravenous narcotism DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: November 4, 1971							
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 11/5/71		24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Marshall P. Hughes		ADDRESS 6387 Gilmor St	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

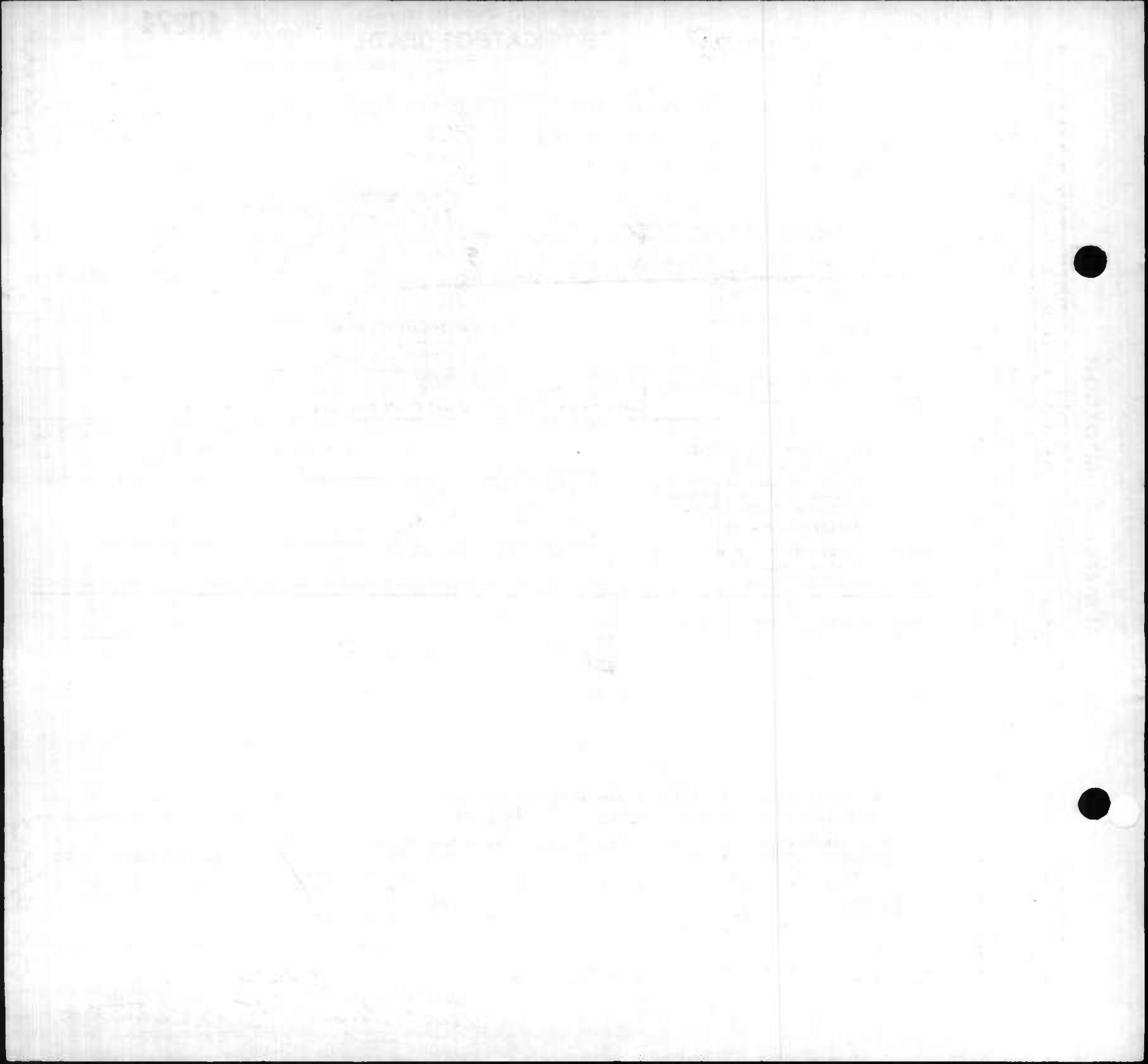
W-325		10273		BALTIMORE CITY HEALTH DEPARTMENT		71 10273	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Samuel Watson				2. DATE AND HOUR OF DEATH 1 NOV 71 0710 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSP. OF BALTIMORE, INC.				A. STATE MARYLAND B. COUNTY 1306			
C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 3457 Chestnut Ave #21211							
5. SEX M	6. RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 30 MAR 07	9. AGE (In years last birthday) 64 yr.	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY BARBER		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS RICHARD WATSON 4537 KESWICK RD.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Metastatic Carcinoma (B) Primary Rectal Adenocarcinoma 6 months (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 31 October 19 71 to 1 November 19 71 that (I) (we) last saw the deceased alive on 1 November 19 71 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE M. Meessen				23B. DATE SIGNED Nov. 1, 71		23C. PHYSICIAN'S NAME (Type) Dr M. Meessen	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE NOV 4, 1971		24C. NAME OF CEMETERY or CREMATORY CONRAINING PARK	
24D. LOCATION (City, town, or county) (State) BALTO. MD.				25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971			
25B. NAME OF REGISTRAR Robert E. Sallee, R.D.				25C. FUNERAL DIRECTOR ADDRESS Paul E. Charnick 3612 Chestnut Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 10274	
K-520 71 10274				REG. NO. 71 10274	
BIRTH NO. 71 10274				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) KING, PEARL M.			2. DATE AND HOUR OF DEATH Oct 31, 1971 12:45 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION 44 THE UNION MEMORIAL HOSPITAL			E. STREET AND NUMBER 3505 CHESTNUT AVE.		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08/09/96	9. AGE (In years last birthday) 75 yrs	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GEORGIA.	
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME unknown.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-85-9156		17. INFORMANT ROBERT MYRIK (SAME)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 184.1 I gastroesophageal carcinoma of the esophagus (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 - 2 yrs		
19A. DATE OF OPERATION 1 Oct 5, 1970			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fair.		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10 Oct 31 19 71 to 2 Oct 31 19 71 that (I) (we) last saw the deceased alive on 2 Oct 31 19 71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mei Pu Lin, M.D.			23B. DATE SIGNED Oct 31, 1971		23C. PHYSICIAN'S NAME (Type) Mei Pu Lin, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 11/3/71		24C. NAME of CEMETERY or CREMATORY NATIONAL
24D. LOCATION (City, town, or county) (State) BALTO. MD.			25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		
25B. NAME OF REGISTRAR Paul E. Chomkowski, M.D.			25C. FUNERAL DIRECTOR Paul E. Chomkowski		
ADDRESS 3617 Chestnut Ave.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

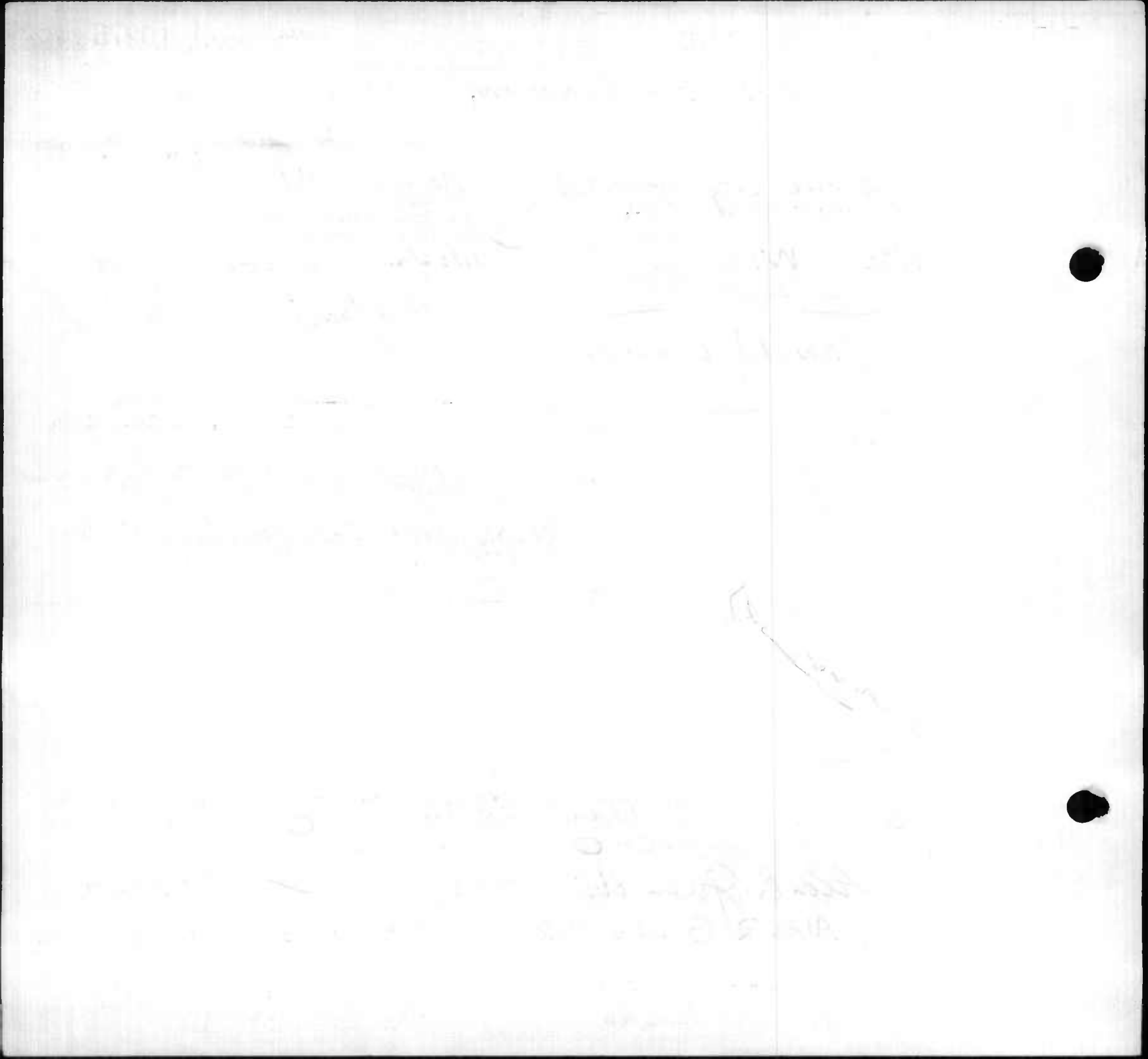
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 10275</u>	
R-263 BIRTH NO. <u>10275</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Richardson, Donald D</u>			2. DATE AND HOUR OF DEATH <u>10/31/71</u> <u>4:05 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Mercy Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>37</u>			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>1710 St. Paul St.</u>		
5. SEX <u>male</u>	6. RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/21/71</u>	9. AGE (In years last birthday) <u>4</u>	If Under 1 Yr. Months: <u>11</u> Days: <u>11</u> Hours: <u>11</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Infant)</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>Donald R. Richardson</u>			14. MOTHER'S MAIDEN NAME <u>Cornelia</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>—</u> ADDRESS <u>—</u>	
18. <u>009111</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiop. arrest</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiop. arrest</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diarrhea, Dehydration.</u>			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>8 hrs.</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>			(C) <u>Suspected (Salmonellosis) Sepsis</u> <u>78 hrs.</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>Yes.</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No.</u>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>10/31</u> 19 <u>71</u> to <u>10/31</u> 19 <u>71</u> that (I) <u>last</u> saw the deceased alive on <u>10/31</u> 19 <u>71</u> and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>10/31/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>—</u>				23D. ADDRESS <u>—</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>transit</u>		24B. DATE <u>Nov. 2, 1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Int. Bethlehem</u>	
24D. LOCATION (City, town, or county) (State) <u>Rocky Mt., North Carolina</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Tarber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Paul L. Donovan</u> ADDRESS <u>3617 Chestnut Ave.</u>			

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

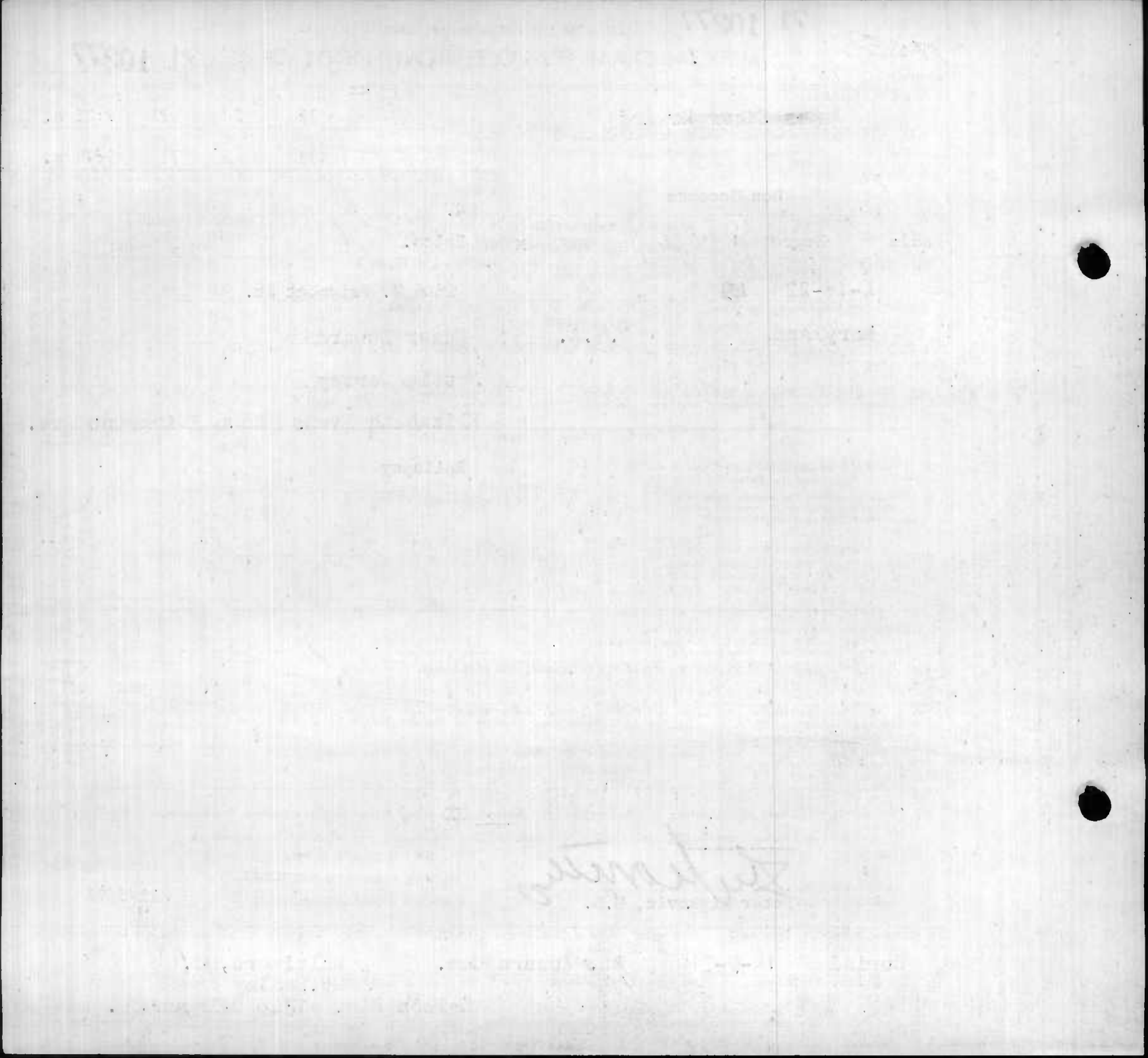
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-550 71 10276		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 10276	
BIRTH NO. <i>B.A. Co. Md.</i>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Baby boy Lowman, Born</i>				2. DATE AND HOUR OF DEATH <i>10/26/71 7:22 PM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Baltimore City Hospital</i> <i>4940 Eastern Avenue Balto., Md 21224</i>				A. STATE <i>MARYLAND</i> B. COUNTY <i>ANNE ARUNDEL</i>			
				C. CITY OR TOWN <i>Annapolis, Md.</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <i>4 Melrob Court 21401</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10/26/71</i>	9. AGE (In years last birthday) <i>14 hrs</i>	10. Under 1 Yr. Months Days Hours Min. <i>14</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Donald Lowman</i>				14. MOTHER'S MAIDEN NAME <i>Bonnie</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>BCH & RECORDS</i>			
				ADDRESS <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>			
18. <i>776.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Severe prematurity</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Respiratory Insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Birth → 14 hrs</i> <i>12 hrs</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>10/26/71 11 AM</i> 19 <i>71</i> to <i>10/26/71 7:22 PM</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>10/26/71 7:21 PM</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Alan R. Green M.D.</i>				23B. DATE SIGNED <i>10/26/71</i>		23C. PHYSICIAN'S NAME (Type) <i>ALAN R. GREEN M.D.</i>	
				23D. ADDRESS <i>Baltimore City Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>11-1-71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore City Hospitals</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland 21224</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Tabor, M.D.</i>		25C. FUNERAL DIRECTOR <i>HOSPITAL DISPOSAL</i>			



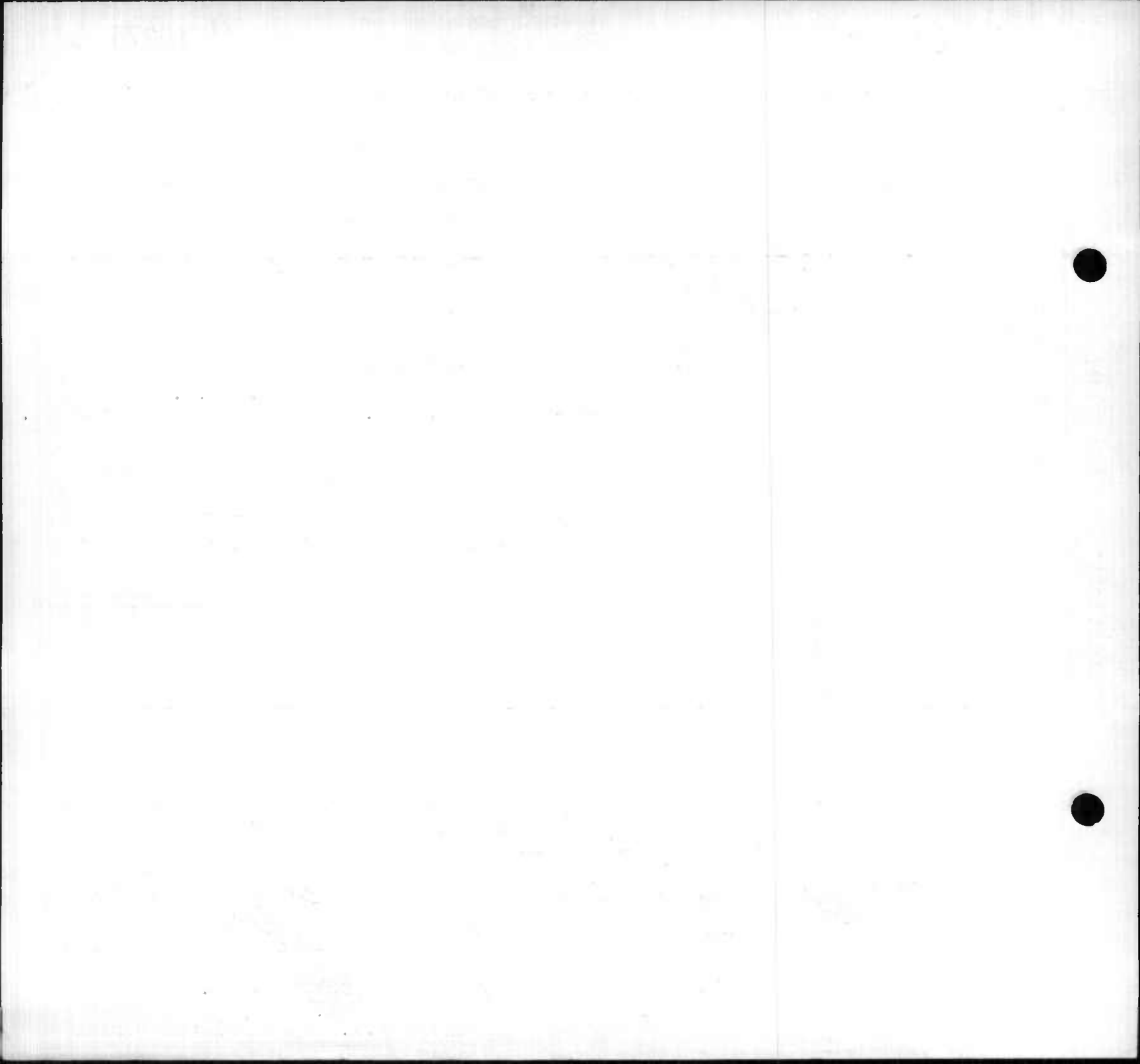
H-630		71 10277		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 71 10277		
BIRTH NO.										
1. NAME OF DECEASED (Type or Print) James Edgar Howard					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 11 5 71 9:22 a.m.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours					3. DATE PRONOUNCED DEAD Month Day Year Hour 11 5 71 9:22 a.m.					
6. SEX male					7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2002	
9. DATE OF BIRTH 4-18-22		10. AGE (In years last birthday) 49		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edgar Howard		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					14B. KIND OF BUSINESS OR INDUSTRY					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)					17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME Mattie Harvey			
18. INFORMANT Elizabeth Evans					ADDRESS 2606 Fairmount Ave.					
19. 345.91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Epilepsy (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
20A. DATE OF OPERATION 2										
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED										
21. AUTOPSY? (Yes or No) yes										
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)					
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					22F. HOW DID INJURY OCCUR?					
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/5/71										
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 11-9-71		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971			25B. NAME OF REGISTRAR Robert E. Bailey, M.D.			25C. FUNERAL DIRECTOR Kelson F.H. ADDRESS 1348 Calhoun St.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 10278	
BIRTH NO. C-425 71 10278					
1. NAME OF DECEASED (Type or Print) MINNIE ALBERTA COLSON		2. DATE AND HOUR OF DEATH Nov. 5, 1971 6 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO.			
FULL NAME OF HOSPITAL OR INSTITUTION MONTEBELLO STATE HOSP. BALTO, MD. 21248		C. CITY OR TOWN BALTIMORE.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX R		6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOODWORKER.		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 11-4-15	
13. FATHER'S NAME WILLIAM REID		14. MOTHER'S MAIDEN NAME LILLIAN REID		9. AGE (In years last birthday) 56	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 227-16-9586		11. BIRTHPLACE (State or foreign country) VIRGINIA -	
		17. INFORMANT Mrs. Geo. Reynolds, 231 Jefferson St.		12. CITIZEN OF WHAT COUNTRY U.S.	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: TONSIL &		(B) CARCINOMA - SOFT PALATE 2 MO. DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) _____			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOV 5 1971 to NOV 5 1971 that (I) (we) last saw the deceased alive on NOV 5 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raymond H. Hermann		23B. DATE SIGNED 11/5/71		23C. PHYSICIAN'S NAME (Type) RAYMOND H. HERMANN	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-10-71		24C. NAME of CEMETERY or CREMATORY Church Cemetery	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Tabor, M.D.		25C. FUNERAL DIRECTOR V. Bailey Kelson F.H. 1348 Calhoun Street	
24D. LOCATION (City, town, or county) (State) Lynchburg, Va.					



Q-200 71 10279

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10279

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JILES QUICK SR.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour November 3, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 3, 1971 9:20 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1538	
9. DATE OF BIRTH 12-12-01		10. AGE (In years last birthday) 69 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 241-05-2089A	
18. INFORMANT Ethel Quick		ADDRESS Same	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 4, 1971			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/6/71	
24C. NAME OF CEMETERY or CREMATORY Abnathus mem. Ch. Bacteriase		24D. LOCATION (City, town, or county) (State) MD.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Wilmington Phillips		ADDRESS 1727 N. Moore St.	

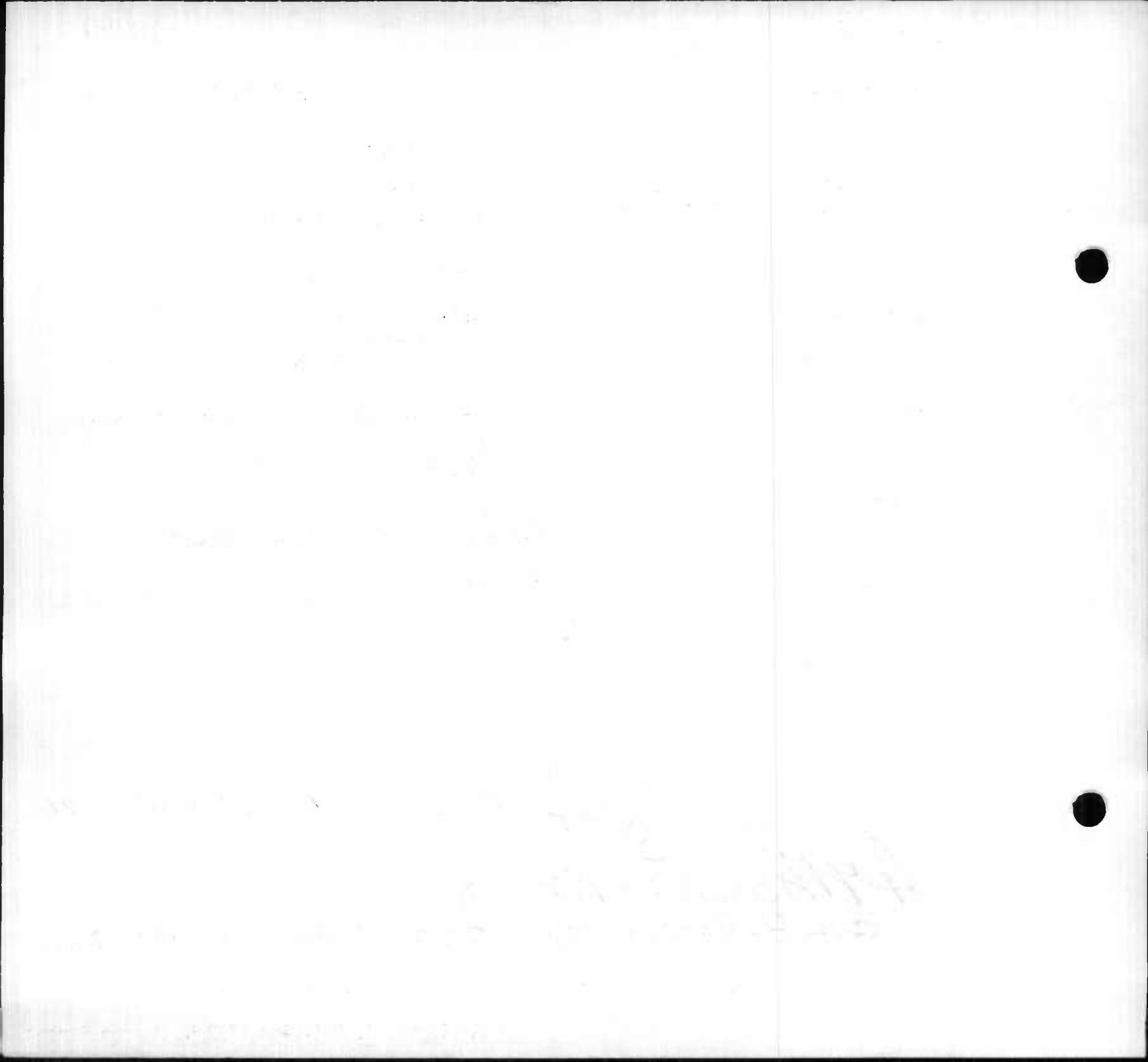
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VALLE VERDE CO

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO.	
J-635		71 10280		71 10280	
1. NAME OF DECEASED (Type or Print) Mira D. Jordan			2. DATE AND HOUR OF DEATH November 5, 1971 6:25 A.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3124 Mondawmin Avenue Baltimore, Maryland 21216			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 1537 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3124 Mondawmin Avenue		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-16-96	9. AGE (In years last birthday) 75	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Shady Dale, Ga.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Davidson			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mrs. Anne Norris 3124 Mondawmin Avenue		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION 4/12/31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). SENILITY			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1970 to Nov 5 1971 that (I) (we) last saw the deceased alive on Nov 5 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. L. Banfield M.D.			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type or Print) G. L. BANFIELD M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Removal			24B. DATE 11-6-71		24C. NAME OF CEMETERY OR CREMATORY Shady Dale Cemetery
24D. LOCATION (City, town, or county) (State) Shady Dale, Ga.			25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			25C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe Street		



W-300 71 10281

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10281

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Alonzo White		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 11 Day 4 Year 71 Hour 9:05 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital		3. DATE PRONOUNCED DEAD Month 11 Day 4 Year 71 Hour 9:05 a.m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Md. Balto.	
9. DATE OF BIRTH 2-18-1910 61		10. AGE (In years last birthday) 61	
11. BIRTH PLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Shadarack White		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Md. 1402	
15. MOTHER'S MAIDEN NAME Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Fannie Bennett	
19. 571.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 11/5/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-9-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) A.A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR William S. Phillips		25D. ADDRESS 1727 N. Meade St.	

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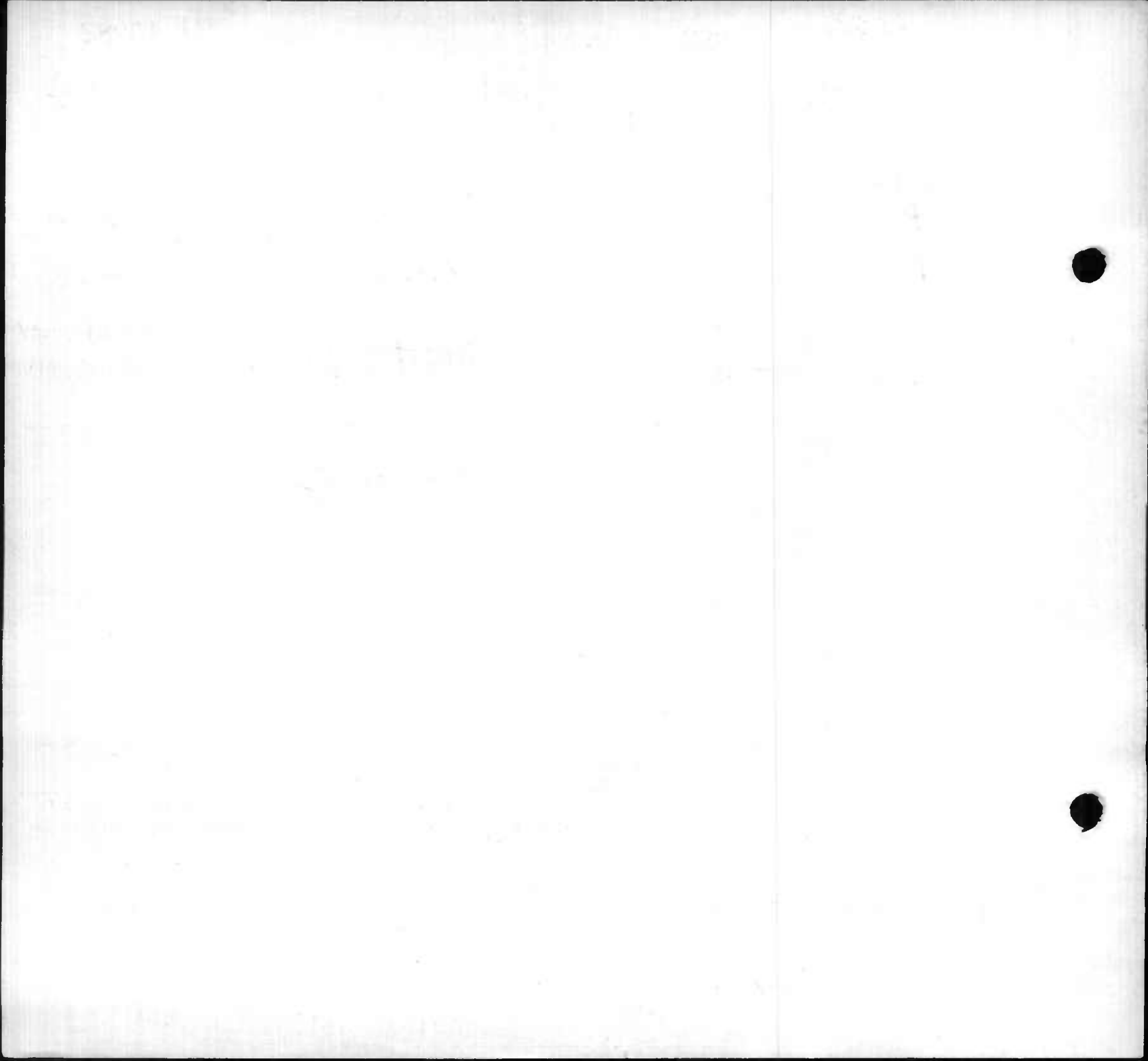
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 10282
BIRTH NO. B-620		10282		
1. NAME OF DECEASED (Type or Print) Brooks Baby girl		2. DATE AND HOUR OF DEATH 10-14-71		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE AA B. COUNTY 5200		
FULL NAME OF HOSPITAL OR INSTITUTION S.B.G.H.		C. CITY OR TOWN G.B. md. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 1008 FAIRWAY AVE. G.B. 21061				
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 90/4/71	9. AGE (in years last birthday) 2 15
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Brooks, Linda		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT 1008 FAIRWAY AVE
18. 777X I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE immaturity DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 10/14 19 71 to 10/14 19 71 that (I) (we) last saw the deceased alive on 10/14 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE E. E. E. E.		23B. DATE SIGNED 10/14/71		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS ANATOMY BOARD OF MARYLAND		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11-4-71		24C. NAME OF CEMETERY or CREMATOR UNIVERSITY MEDICAL SCHOOL
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHO



CERTIFICATE OF DEATH

REG. NO. 71 10283

BIRTH NO. 71-18068 71 10283

1. NAME OF DECEASED
(Type or Print)

Baby Boy Taylor

2. DATE AND HOUR OF DEATH

11/5/71 11 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Baltimore City Hosp ICU
4940 Eastern Avenue Baltimore, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Balt Md.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

711 Sheridan Avenue 21212

5. SEX

Male

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

10/8/71

9. AGE (In years
last birthday)

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

28

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Lorraine E. Taylor

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

4940 Eastern Avenue

BCH: RECORDS

Baltimore, Maryland

21224

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Respiratory Insufficiency

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

2° to MICKITZ-WILSON syndrome

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 1/2 weeks

(B)

DUE TO, OR AS A CONSEQUENCE OF:

PNEUMATIVITY

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/2/71 19 71 to 11/5/71 19 71
that (I) (we) last saw the deceased alive on 11/5 19 71 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Alan R. Green MD

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

11/5/71

23C. PHYSICIAN'S
NAME (Type)

ALAN R. GREEN MD

23D. ADDRESS

4940 Eastern Avenue Baltimore,
Baltimore City Hosp Maryland24A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

24B. DATE

11-10-71

24C. NAME OF CEMETERY or CREMATORY

Baltimore City Hospitals

24D. LOCATION

Baltimore, Maryland 21224

25A. DATE REC'D BY HEALTH DEPT.

NOV 23 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

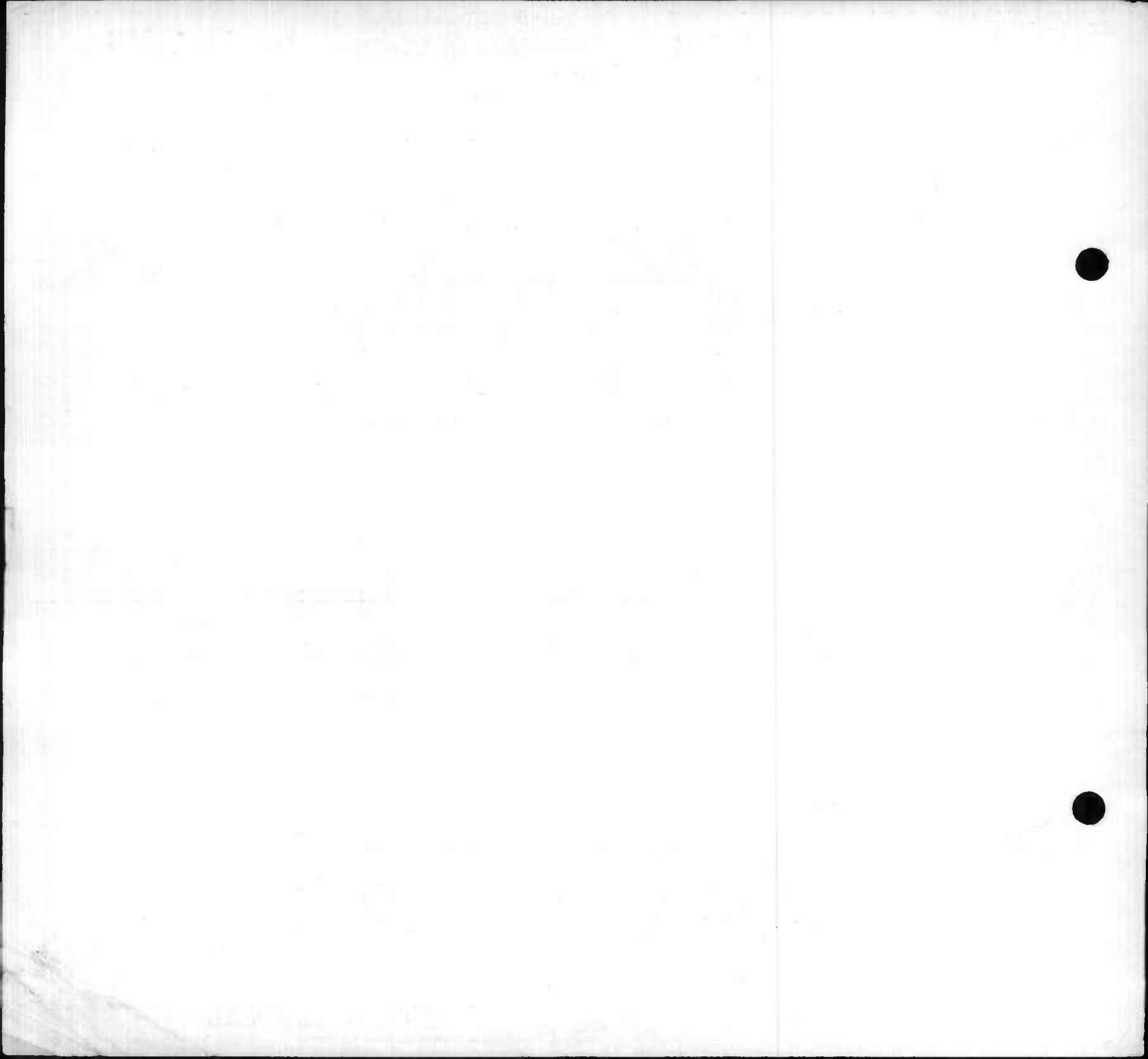
25C. FUNERAL DIRECTOR

HOSPITAL DISPOSAL

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



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J-525 71 10284		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10284	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Johnson, William</u>		2. DATE AND HOUR OF DEATH <u>10/29/71</u> <u>A.</u> <u>M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u> <u>48</u>		C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>416 ST. MARY AVE</u>			
5. SEX <u>M</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/13/09</u>	9. AGE (In years last birthday) <u>62</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Patients CHART</u>	
18. <u>412.4 I</u> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) <u>Occlusion - 95% of internal carotid artery</u> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(C) <u>Aseps</u>			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>10/24/71</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Occlusion of internal carotid</u>	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10/24</u> 19 <u>71</u> to <u>10/29</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/24</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harold J. Kaplan</u>		23B. DATE SIGNED <u>10/29/71</u>		23C. PHYSICIAN'S NAME (Type) <u>HAROLD J. KAPLAN</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>11-8-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>UNIVERSITY MEDICAL SCHOOL</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, R.D.</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHO</u>	

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BALTIMORE CITY HEALTH DEPARTMENT

71 10285

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10285

1. NAME OF DECEASED (Type or Print) <i>Alice Turner</i>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 11 6 71 955 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>435 BG Hosp.</i>		3. DATE PRONOUNCED DEAD Month Day Year Hour <i>11 6 71 955 P.M.</i>	
6. SEX <i>F</i>		7. RACE <i>Neg. N</i>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>AA</i> C. CITY OR TOWN <i>Balto</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <i>7-25-35</i>		10. AGE (In years, lost birthday) <i>36</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Wm M Turner Jr</i>		14. STREET AND NUMBER <i>219 Bolivar Ave</i>	
15. MOTHER'S MAIDEN NAME <i>Tennessee Reynolds</i>		16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk typist</i>	
17. KIND OF BUSINESS OR INDUSTRY		18. SOCIAL SECURITY NO. <i>212-36-8104</i>	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		20. INFORMANT <i>Mrs Tennessee V. Turner</i>	
21. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
22. DATE OF OPERATION <i>2</i>		23. CONDITION FOR WHICH OPERATION WAS PERFORMED	
24. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
26. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		27. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		29. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <i>Werner H. Spitz</i>		DEPUTY CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		25. DATE <i>11/10/71</i>	
26. NAME OF CEMETERY or CREMATORY <i>Mt Auburn</i>		27. LOCATION (City, town, or county) (State) <i>Balto MD</i>	
28. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1971</i>		29. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
30. FUNERAL DIRECTOR <i>Pennell's. Oden</i>		31. ADDRESS <i>4101 Edmondson Ave</i>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10286	
71 10286 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MC FADDEN, DR ALBERT DAVID		NOVEMBER 6, 1971 3:00A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL			A. STATE MARYLAND 21218 2759		
			C. CITY OR TOWN BALTIMORE		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 4313 MARBLE HALL ROAD		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 26 87	9. AGE (In years last birthday) 83	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN		10B. KIND OF BUSINESS OR INDUSTRY Own Business		11. BIRTHPLACE (State or foreign country) ALABAMA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME XXX DANIEL MC FADDEN			14. MOTHER'S MAIDEN NAME SARAH RHODES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 216091976		17. INFORMANT CATON AVES. BALTO., MD. 21229 ST. AGNES HOSPITAL RECORDS, WILKENS AND	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bacteria / septic pneumonia (B) Post op - CA coloy - DUE TO, OR AS A CONSEQUENCE OF: ASCVD (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CANCER		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from OCTOBER 7 1971 to NOVEMBER 6 1971 that (X) (we) lost saw the deceased alive on NOVEMBER 6 1971 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death.					
23A. SIGNATURE Leroy B. Buckler M.D.				23B. DATE SIGNED 11 6 71	
23C. PHYSICIAN'S NAME (Type) LEROY B. BUCKLER M.D.				23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-8-71		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212	

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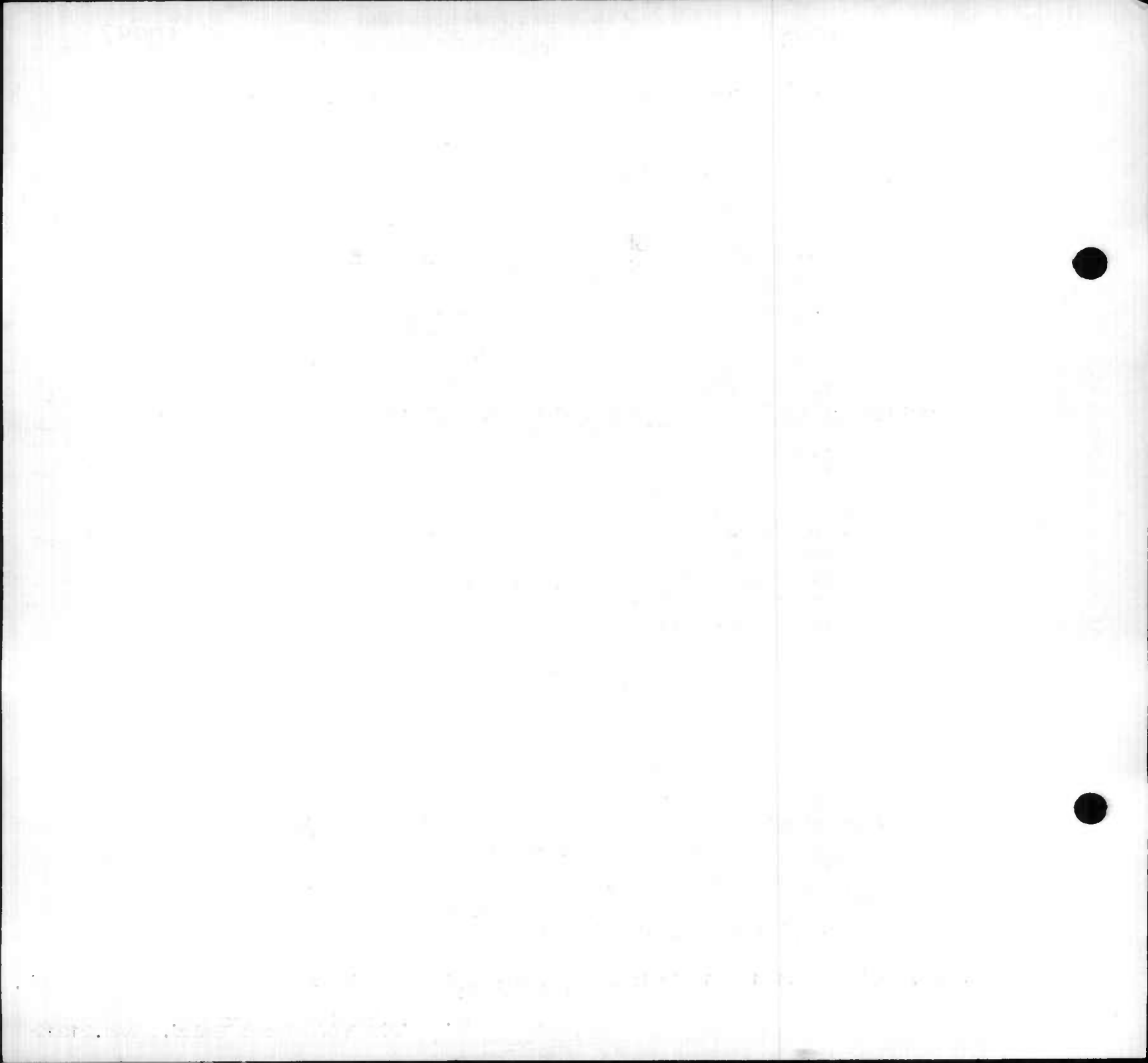
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FUNERAL DIRECTOR: IMPORTANT

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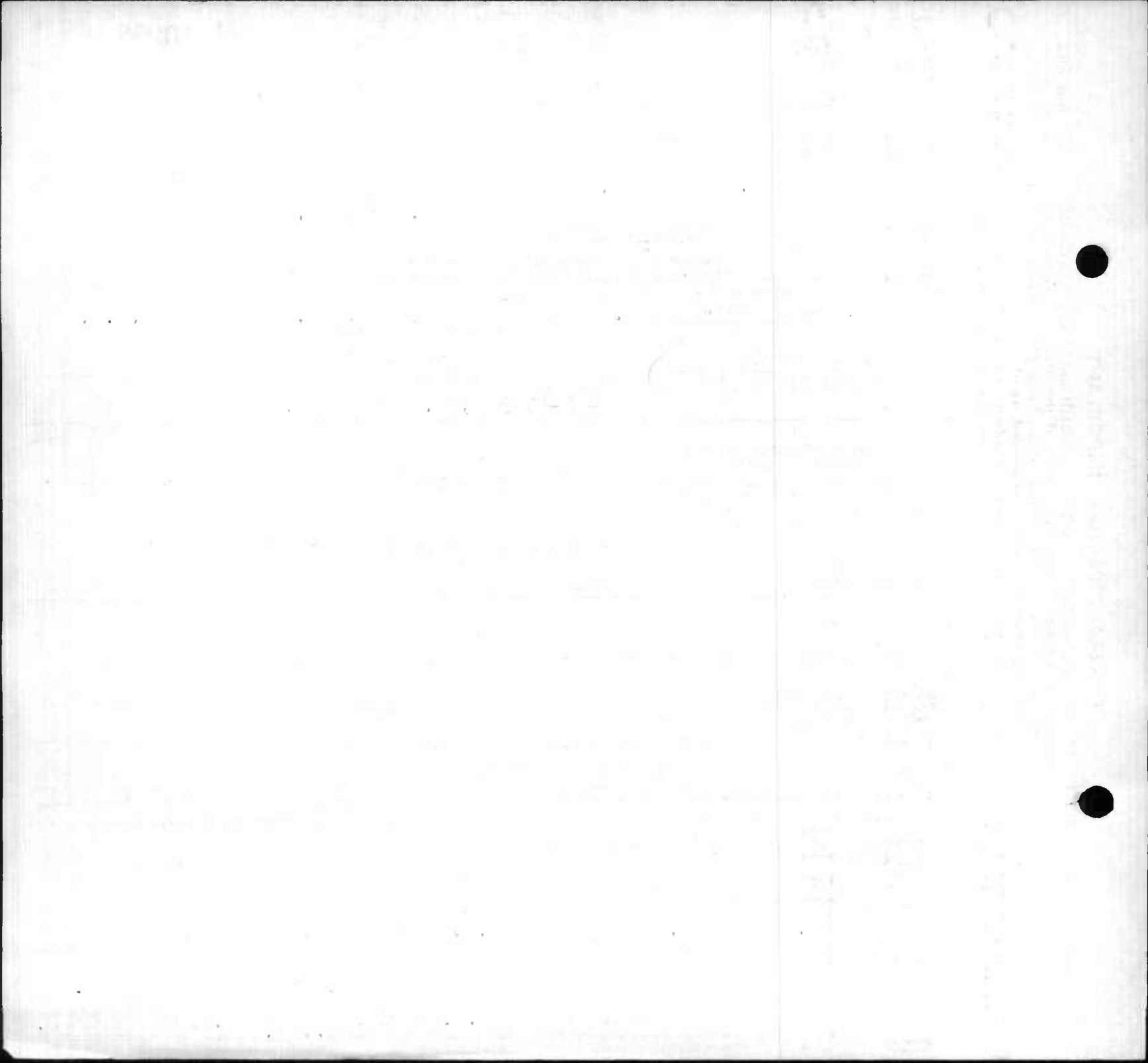
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 10287</u>	
BIRTH NO. <u>71 10287</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>ROBERT F. IDE</u>		2. DATE AND HOUR OF DEATH <u>11/6/71</u> <u>8 am</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY OF MARYLAND HOSP.</u> <u>BALTIMORE, MD</u>		C. CITY OR TOWN <u>OWINGS MILLS</u>	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-4-1894</u>	
9. AGE (in years last birthday) <u>77</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COMPTROLLER</u>	
11. BIRTHPLACE (State or foreign country) <u>DORCHESTER, MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES CALDWELL IDE</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH FOLLANSBEE</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W.W.I.</u>		16. SOCIAL SECURITY NO. <u>011-03-6452A</u>	
17. INFORMANT <u>MRS. DEAN B. ELISON</u>		ADDRESS <u>(SAME)</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days</u> <u>21 days</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>11/4/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ac. renal failure</u>	
20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>11/5</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that <u>W</u> (this hospital) attended the deceased from <u>10/27</u> <u>19 71</u> to <u>11/6</u> <u>19 71</u> that (I) <u>we</u> last saw the deceased alive on <u>11/5</u> <u>19 71</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Rudolph W. Koster MD</u>		23B. DATE SIGNED <u>11/6/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>RUDOLPH W. KOSTER MD</u>		23D. ADDRESS <u>UNIV. OF MD HOSP.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Rem. Burial</u>		24B. DATE <u>11-10-71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Puritan Lawn Memorial Park,</u>		24D. LOCATION (City, town, or county) (State) <u>West Peabody, Mass.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Jarvey, M.D.</u>	
25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Road Balto., Md. 21212</u>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 10288</u>	
BIRTH NO. <u>71 10288</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Morris Harris</u>			2. DATE AND HOUR OF DEATH <u>November 6, 1971 12:45 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 712 E. 36th St.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>903</u>		
			C. CITY OR TOWN <u>Baltimore 21218</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>712 E. 36th St.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/15/1908</u>		9. AGE (in years last birthday) <u>63</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor-Electrical Lab. ments</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Surgical Instruments</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Samuel Harris</u>		
14. MOTHER'S MAIDEN NAME <u>Lena Magid</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>214-03-2763</u>			17. INFORMANT <u>Mrs. Lillian E. Harris (Same)</u>		
18. <u>41231</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary artery disease 8 years</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>paraplegia, psoriasis 48 years, 8 years</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>July 19 69</u> to <u>October 6 19 71</u> that (I)-(we) last saw the deceased alive on <u>Oct 15 19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Nathan R. Sklar, MD</u>			23B. DATE SIGNED <u>11/8/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Nathan R. Sklar</u>
23D. ADDRESS <u>U.S. Public Health Service Hospital</u>			23E. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>11/9/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith</u>
24D. LOCATION <u>Baltimore Md.</u>			24E. ADDRESS <u>4905 York Rd.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1971</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Baltimore, Md. 21212</u>



S-130

71 10289

BALTIMORE CITY HEALTH DEPARTMENT

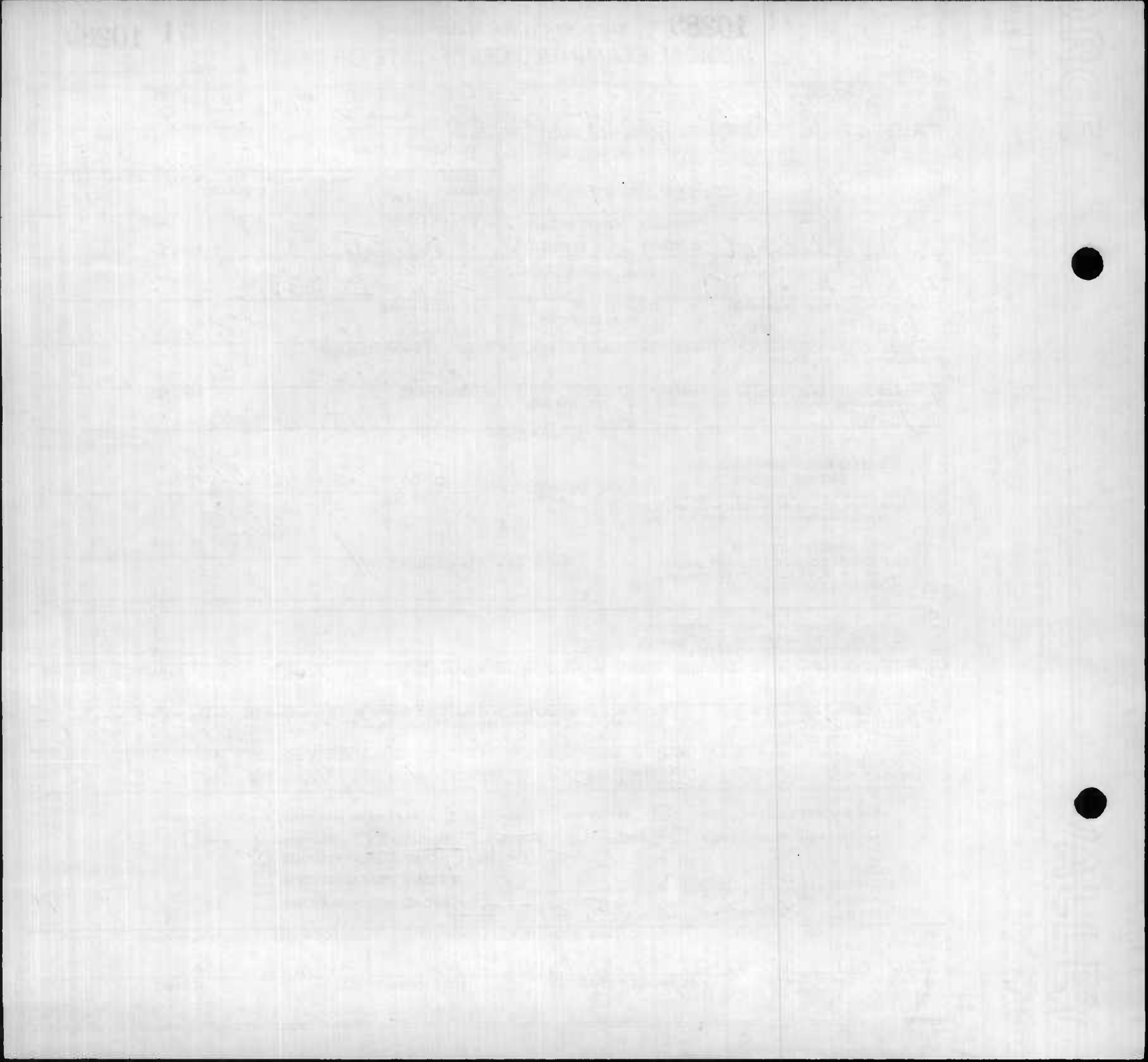
71 10289

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

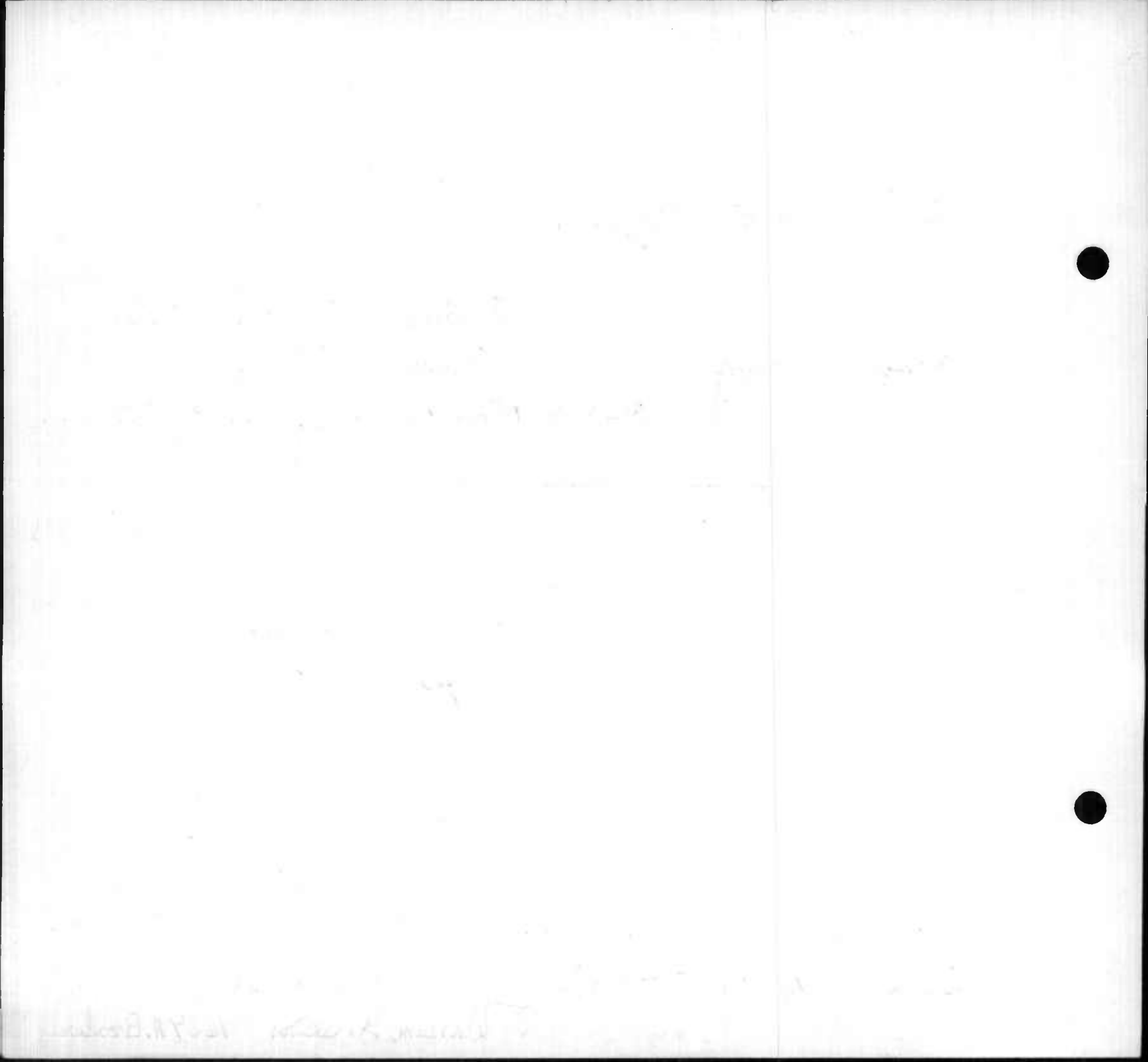
1. NAME OF DECEASED (Type or Print) <i>Charles E. Skipwith</i>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> 11 5 71 11:50 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>48 MA General Hosp</i>		3. DATE PRONOUNCED DEAD Month Day Year Hour <i>11 5 71 11:50 P.M.</i>	
6. SEX <i>M</i>		7. RACE <i>Negro</i>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution's residence before admission) A. STATE <i>MA</i> B. COUNTY <i>14-03</i>	
9. DATE OF BIRTH <i>4/3/54</i>		10. AGE (in years lost birthday) <i>17</i>	
11. BIRTHPLACE (State or foreign country) <i>BAIT. md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Charles Skipwith</i>		14. MOTHER'S MAIDEN NAME <i>Bernice Winder</i>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		17. SOCIAL SECURITY NO. <i>215-60-4625</i>	
18. INFORMANT <i>Mother 1728 McKeen St.</i>		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Gunshot wound</i> <i>17 chest</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION <i>2</i>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>House</i>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <i>1409 Myrtle Ave</i>		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>11 5 71 11:40</i>	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <i>Not during altercation</i>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner H. Spitz</i> M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <i>Werner H. Spitz</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>11.7.71</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-11-71</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Arlington Nat. Bk.</i>		24D. LOCATION (City, town, or county) (State) <i>Arlington Va.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Chas. E. Hughes</i>		ADDRESS <i>1532 Hollins St (23)</i>	



FUNERAL DIRECTOR: IMPORTANT

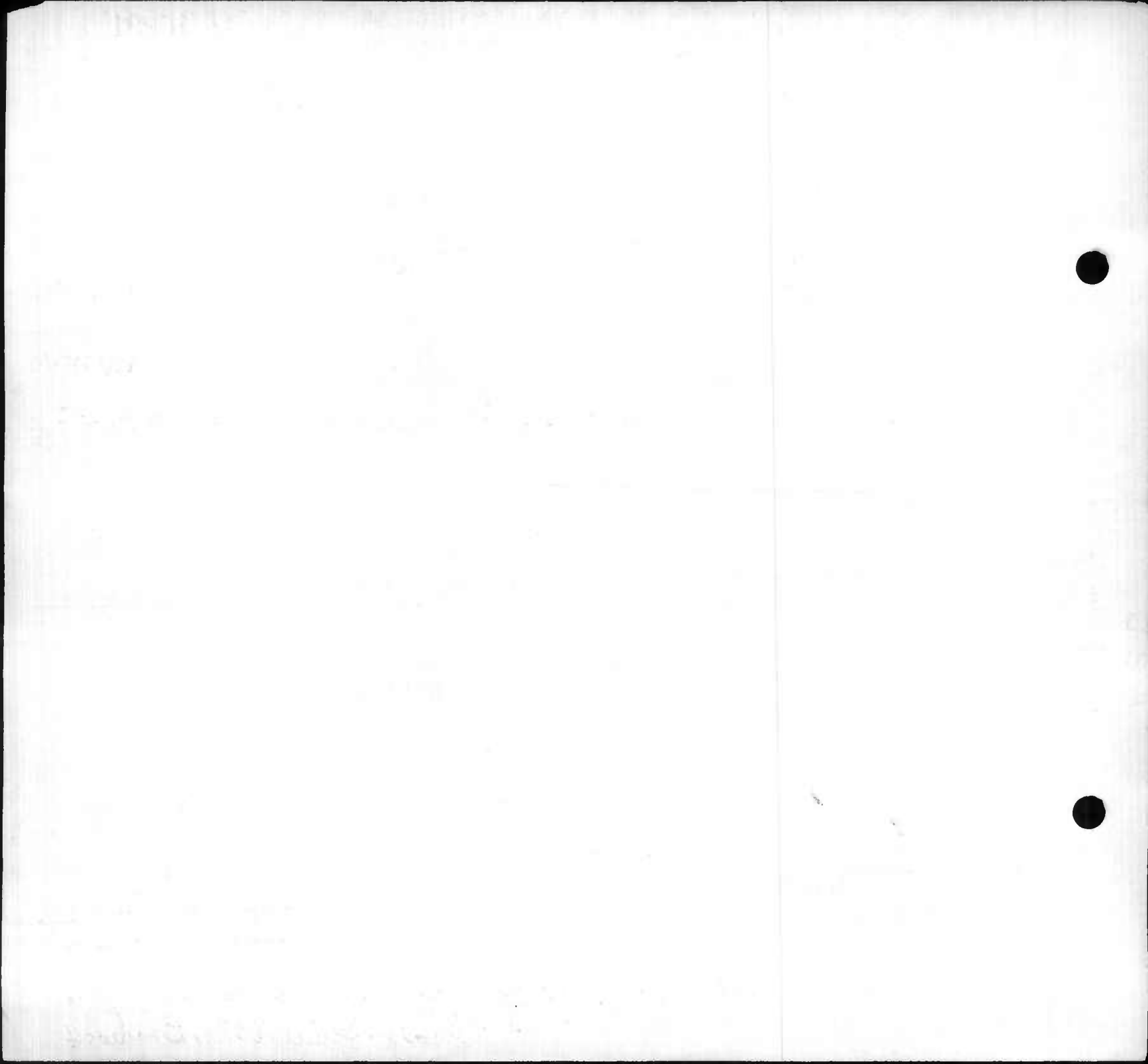
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-620 71 10290		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 10290	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mr. Dorsey Oscar</i>		2. DATE AND HOUR OF DEATH <i>Nov. 4, 1971 4:30 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>1512</i>		5. CITY OR TOWN <i>BALTIMORE</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital - Baltimore Ave</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <i>MALE</i>		7. RACE <i>Negro</i>		8. DATE OF BIRTH <i>8/7/88</i>	
9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (in years last birthday) <i>83</i>		11. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Postal Carrier</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Maryland</i>	
13. FATHER'S NAME <i>Henry Dorsey</i>		14. MOTHER'S MAIDEN NAME <i>Annie Dorsey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-40-1897</i>		17. INFORMANT <i>Emma Dorsey 2900 Keyworth Ave.</i>	
18. <i>FXS X I</i>		CAUSE OF DEATH		ADDRESS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Bilateral Bronchopneumonia</i>		(APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH) <i>20 hrs.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>Chronic Bronch Syndrome</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes.</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Notify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Nov 4</i> 19 <i>71</i> to <i>Nov 4</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>Nov 4</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>C. Thananopavarn M.D.</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Nov. 4</i>	
23C. PHYSICIAN'S NAME (Type) <i>CHALEMPHOL THANANOPAVARN M.D.</i>		23D. ADDRESS <i>SINAI HOSPITAL OF BALTIMORE IN.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>11/9/71</i>		24C. NAME of CEMETERY or CREMATORY <i>Trinity Calvary</i>	
24D. LOCATION (City, town, or county) (State) <i>Anne Arundel Co. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
25C. FUNERAL DIRECTOR <i>William J. Spier</i>		ADDRESS <i>1639 N. Broadway</i>			



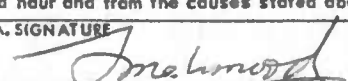
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		71 10291	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO.	
JOHN McCLAIN		11/5/71		6:26 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		704	
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS		A. STATE MD.		B. COUNTY (NONE)	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
33		E. STREET AND NUMBER 902 N. WOLFEST.			
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/10/03	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME ROSE YOUNG		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-18-0107		17. INFORMANT Roxie McClain	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE ANOXIA DUE TO, OR AS A CONSEQUENCE OF: (B) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF: (C) ? PULMON. EDEMA ? PULM-EMBOLI		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN. 14 HRS.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). S/D CVA, FEVER OAT CELL CARCINOMA, METASTATIC; KASCUD.		19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from OCT. 4 1971 to NOV 5 1971 that (we) last saw the deceased alive on NOV. 5 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce M. Greene		23B. DATE SIGNED 11/5/71			
23C. PHYSICIAN'S NAME (Type) BRUCE M. GREENE		23D. ADDRESS JOHNS HOPKINS HOSPITAL 601 N. BROADWAY, BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/8/71		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	
24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR William J. Spivey		25D. ADDRESS 1639 N. Broadway			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10292	
S-352 71 10292				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) STENCIL MICHAEL WILLIAM			2. DATE AND HOUR OF DEATH 11/06/71 11:35AM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1902		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			E. STREET AND NUMBER 222 S CAREY STREET 21223		
5. SEX MALE	6. RACE CAUCASION	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02/05/05	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10B. KIND OF BUSINESS OR INDUSTRY BALTO CITY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME MICHAEL STENCIL			14. MOTHER'S MAIDEN NAME LORETTA (ABEL)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220 09 6445	17. INFORMANT ADDRESS 5 ST AGNES HOSPITAL BALTO MD 21229		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cancer of Right upper lobe of Lung Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Liver and Anemia (B) DUE TO, OR AS A CONSEQUENCE OF: Azotemia (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 11/04/71 19 to 11/06/71 19 that (X) (we) last saw the deceased alive on 11/06/71 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) (not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 11 6 71	
23C. PHYSICIAN'S NAME (Type) TARIQ MAHMOOD M.D.				23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/9/71		24C. NAME OF CEMETERY OR CREMATORY Louisa Park Cem	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971			
25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR John J. Cowan + Son Inc.			
25D. ADDRESS 901 Hollins St.		25E. ADDRESS 23, Md.			

1900

JULY 20 1900

LOUETTA (Aunt)
MARYLAND
CITY
EDUCATION

2000 HOSPITAL

STATE OF MARYLAND
JULY 20 1900
JULY 20 1900
JULY 20 1900

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-468</u>		REG. NO. <u>71 10293</u>	
1. NAME OF DECEASED (Type or Print) <u>MILLER, HELEN BLANCHE</u>		2. DATE AND HOUR OF DEATH <u>NOVEMBER 6, 1971</u> <u>4:10 A. M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>ST AGNES HOSPITAL</u> <u>CATON & WILKENS AVENUES</u> <u>BALTIMORE, MARYLAND 21229</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>1316</u> <u>LAFAYETTE AVENUE</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>05/30/19</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TELEPHONE OPERATOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>C. & P. Telephone Co.</u>	9. AGE (In years last birthday) <u>52</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLINTON P. GRIFFIN</u>		14. MOTHER'S MAIDEN NAME <u>HELEN B. BITZER</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>		16. SOCIAL SECURITY NO. <u>214-03-0786</u>	
17. INFORMANT <u>Harold J. Miller, 1316 Lafayette Ave., 21207,</u> <u>ST AGNES' RECORDS CATON & WILKENS AVES</u>		ADDRESS	
18. <u>43101</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hypertension</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>NOVEMBER 6</u> 19 <u>71</u> to <u>NOVEMBER 6</u> 19 <u>71</u> that <u>(X)</u> (we) last saw the deceased alive on <u>NOVEMBER 6</u> 19 <u>71</u> and that <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>D. S. Lee</u>		23B. DATE SIGNED <u>Nov. 6, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>KIM LEE M.D.</u>		23D. ADDRESS <u>BALTO MD 21229</u> <u>ST AGNES HOSPITAL CATON & WILKENS AVES</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/9/71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Baltimore, Md. 21208</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Loring Byers, 8728 Liberty Rd. Randallstown, Md 21133</u>		ADDRESS	

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S-365 71 10294
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 10294

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHARLES S. STERN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> November 4, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour November 4, 1971 5:35 A. M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1301	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH MARCH 23, 1911		10. AGE (In years last birthday) 60	11. BIRTHPLACE (State or foreign country) E. ORANGE, NEW JERSEY		12. CITIZEN OF USA
13. FATHER'S NAME FREDERICK STERN		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		15. MOTHER'S MAIDEN NAME EDNA HANLINE	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 216-03-4915		18. INFORMANT MRS. CHARLES S. STERN, 2501 EUTAW PL. #21217	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.91 Ruptured myocardial infarct with cardiac tamponade (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) (Partial) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 4, 1971					
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 11-5-71		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971 Robert E. Tabor, M.D.		25B. NAME OF REGISTRAR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD BALTIMORE, MD. 21215	

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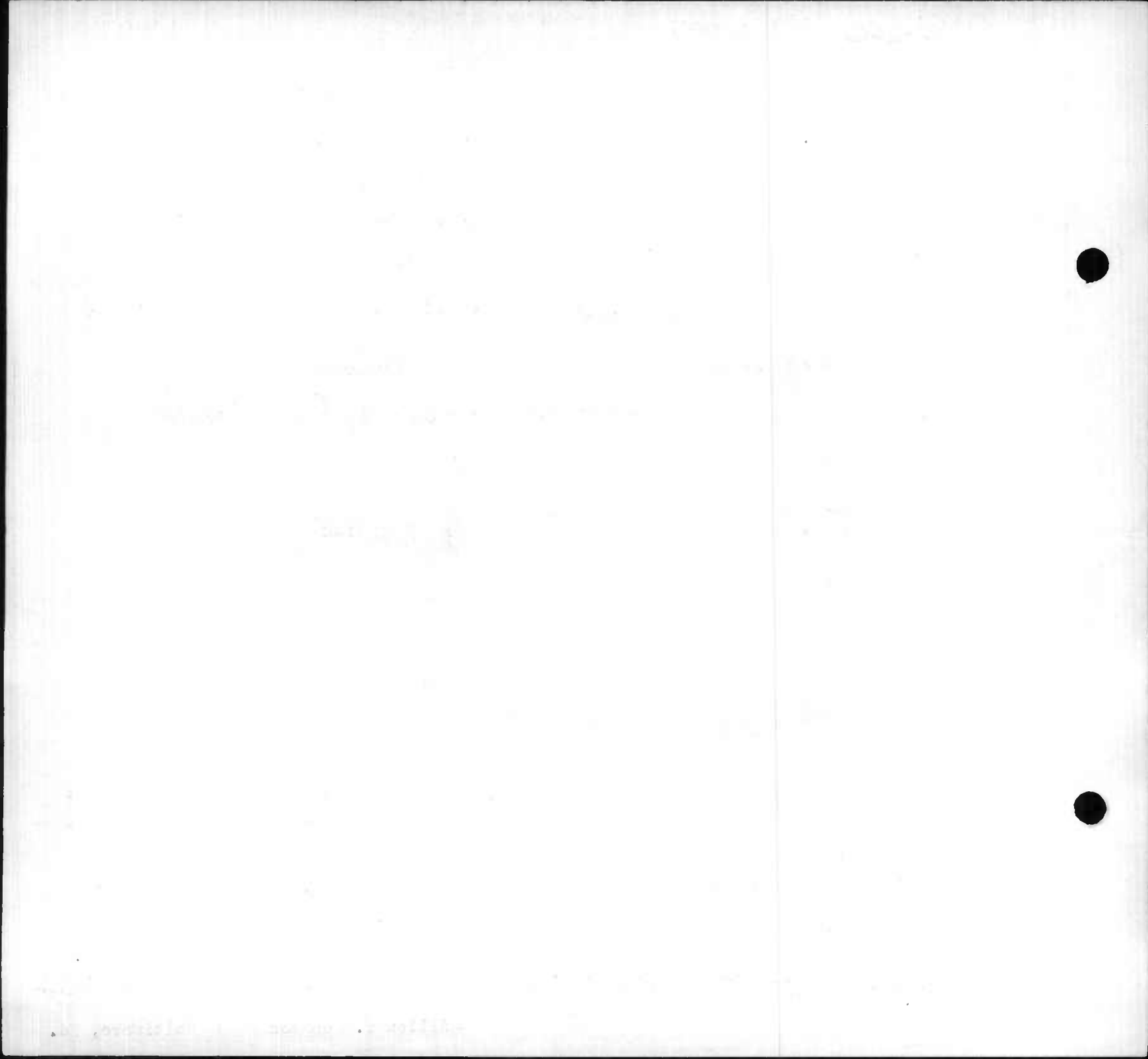
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

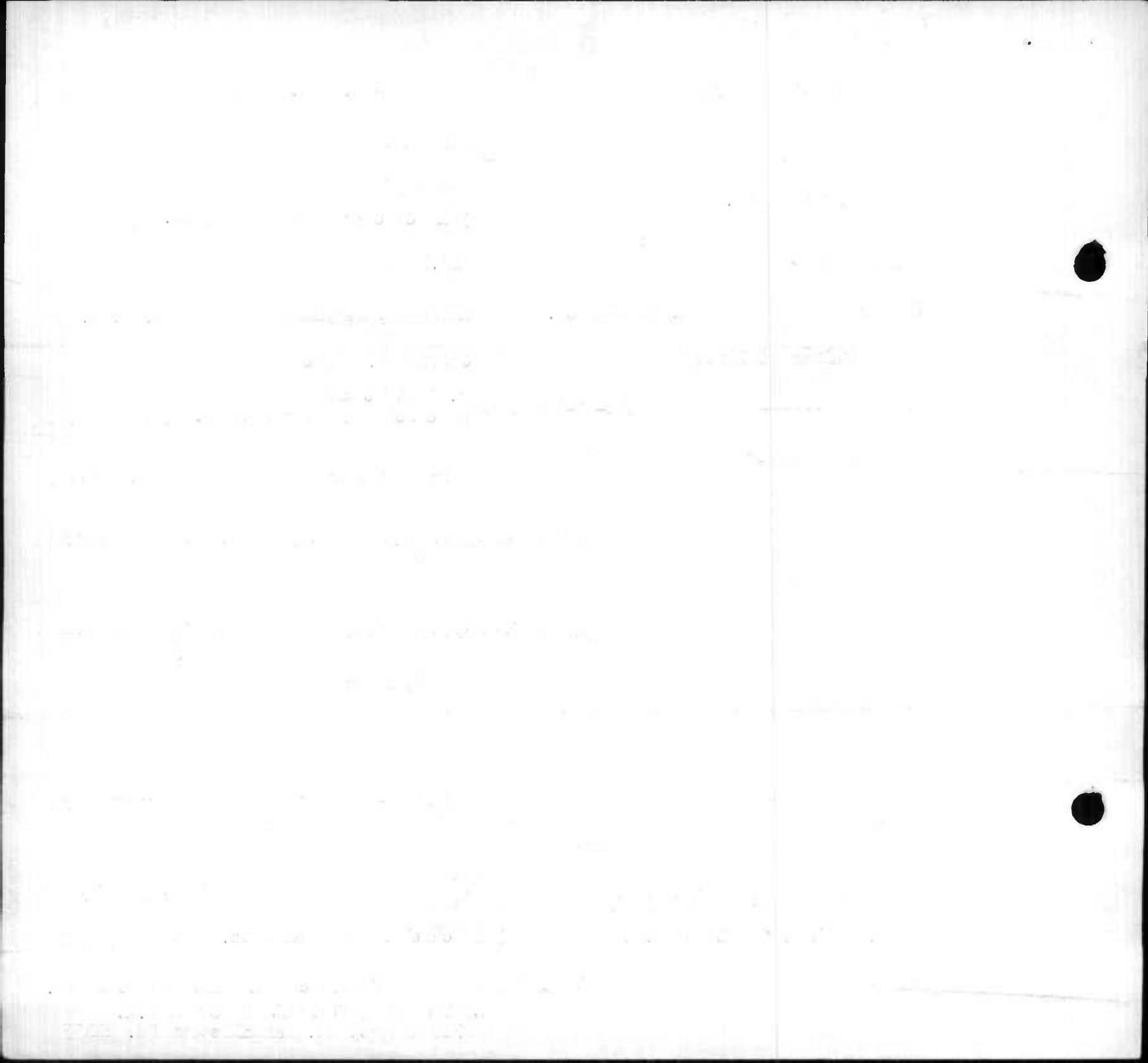
W-600 71 10295		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 10295	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Wore, Dennis</i>		2. DATE AND HOUR OF DEATH <i>10-28-71 7:00P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>B. City</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Key Circle Hospice 1219 Eubank Place Bkto, Md.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>1116 W. Franklin Street</i>	
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>35-1899</i>	9. AGE (In years last birthday) <i>72</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Ship YARD</i>		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>239-05-9350</i>		17. INFORMANT <i>RECORDS - KEY CIRCLE HOSPICE</i>	
18. <i>185X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Cardip. Insuff. 2nd</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) <i>Ca of the Prostate</i> DUE TO, OR AS A CONSEQUENCE OF:		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined) <i>none</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Oct. 19</i> 19 <i>71</i> to <i>Oct 28</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>Oct 28</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>H. E. Bondy</i>		23B. DATE SIGNED <i>10-28-71</i>		23C. PHYSICIAN'S NAME (Type) <i>H. E. Bondy</i>	
23D. ADDRESS <i>1219 Eubank Place</i>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-1-71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mount Olive</i>	
24D. LOCATION (City, town, or county) (State) <i>Pickens So. Carolina</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 8</i>		25B. NAME OF REGISTRAR <i>W. E. Johnson</i>		25C. FUNERAL DIRECTOR <i>William E. Johnson</i>	
ADDRESS <i>Baltimore, Md.</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

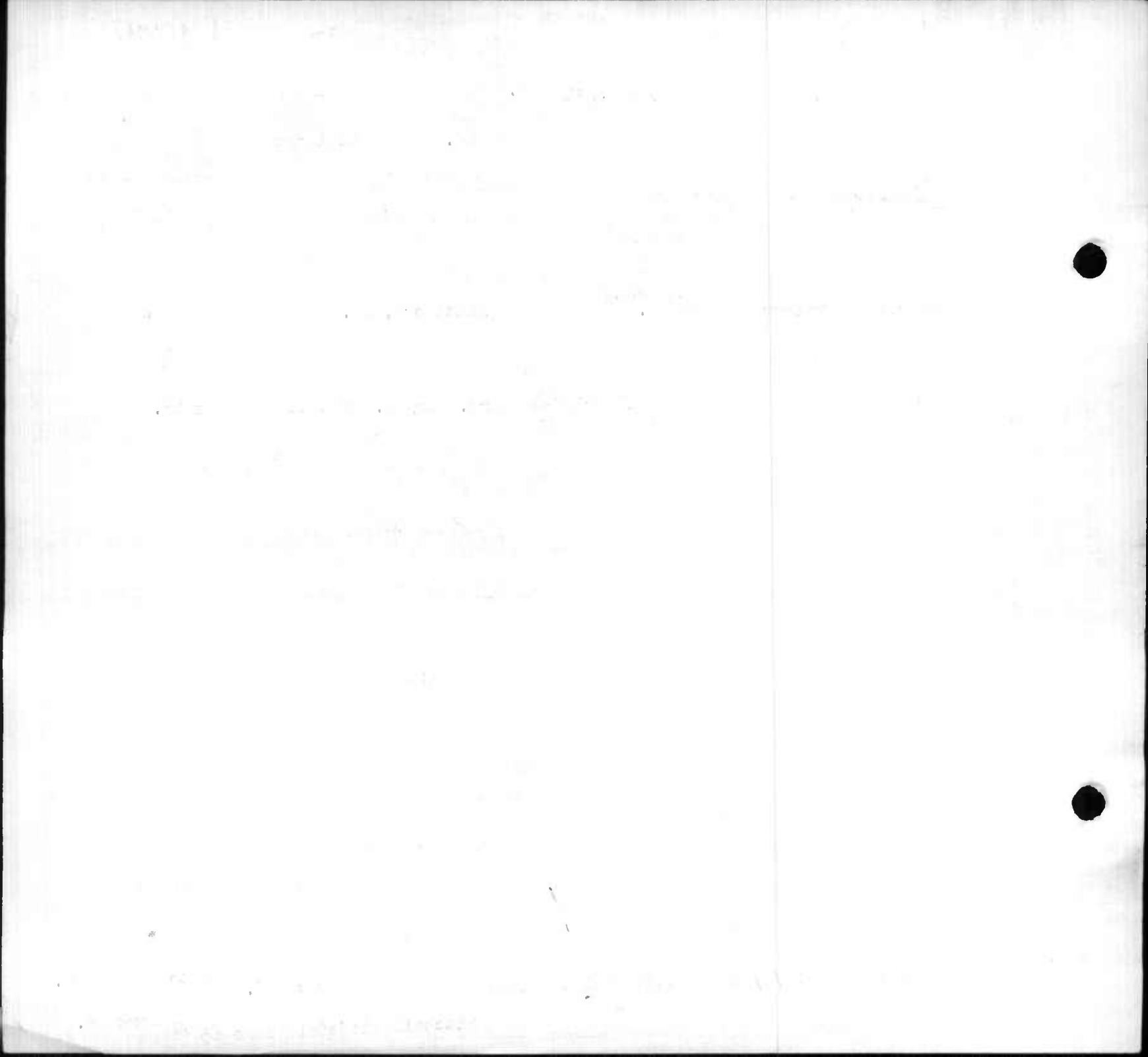
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 10296</u>	
BIRTH NO. <u>C-460</u>		71 10296			
1. NAME OF DECEASED (Type or Print) <u>WALTER COLLIER</u>			2. DATE AND HOUR OF DEATH <u>SAT. NOV. 6, 71</u> <u>3 10 A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34</u> <u>BON SECOURS HOSPT.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1401</u>		
5. SEX <u>Male</u>		6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/1884</u>	9. AGE (In years last birthday) <u>87</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Gilpin Drug Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
13. FATHER'S NAME <u>Walter Collier</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>212-07-5968A</u>		17. INFORMANT <u>Mrs. Betty Collier</u> <u>301 McMechen Memorial Apts. Baltimore 21217</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>HASCD</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II</u> <u>Cerebral arteriosclerosis - severely</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-30-1968</u> to <u>11-4-1971</u> that (I) (was) last saw the deceased alive on <u>11-4-1971</u> and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Angel S. Gonzalez</u>			23B. DATE SIGNED <u>11-6-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>DR. ANGEL S. GONZALEZ M.D.</u>			23D. ADDRESS <u>301 McMechen Memorial Apts. Baltimore, 21217</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/9/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>LOUDON PARK CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>Frederick Rd. Baltimore City Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1971</u>		25B. NAME OF REGISTRAR <u>E. J. ...</u>	
25C. FUNERAL DIRECTOR <u>LORING BIER'S FUNERAL DIRECTORS P.A.</u>		ADDRESS <u>8728 Liberty Rd. Randallstown Md. 21133</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 10297	
BIRTH NO. L-15071 10297					
1. NAME OF DECEASED (Type or Print) LAVIN, JOHN George Sr.			2. DATE AND HOUR OF DEATH 11-2-71 1230 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY of Maryland Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Rodgers Forge D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 229 Hopkins Road Balto.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-26-19	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Supervisor		10B. KIND OF BUSINESS OR INDUSTRY Continental Can Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME John J. Lavin			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO. 219 010524		17. INFORMANT ADDRESS Mrs. Mary M. Lavin 229 Hopkins Rd.	
18. 39571 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Left Ventricular Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Aortic Stenosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 11-2-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic Stenosis		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-20 19 71 to 11-2 19 71 that (I) (we) last saw the deceased alive on 11-2 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gopalakrishnan			23B. DATE SIGNED 11 2 71		
23C. PHYSICIAN'S NAME (Type) DR GOPALA KRISHNAN			23D. ADDRESS UNIVERSITY HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/5/71		24C. NAME OF CEMETERY or CREMATORY Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Frederick Rd. Balto Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		25C. FUNERAL DIRECTOR ADDRESS Mitchell Wiedefeld Home 6500 York Rd.	



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D-362 71 10298

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 71 10298

BIRTH NO. REG. NO.

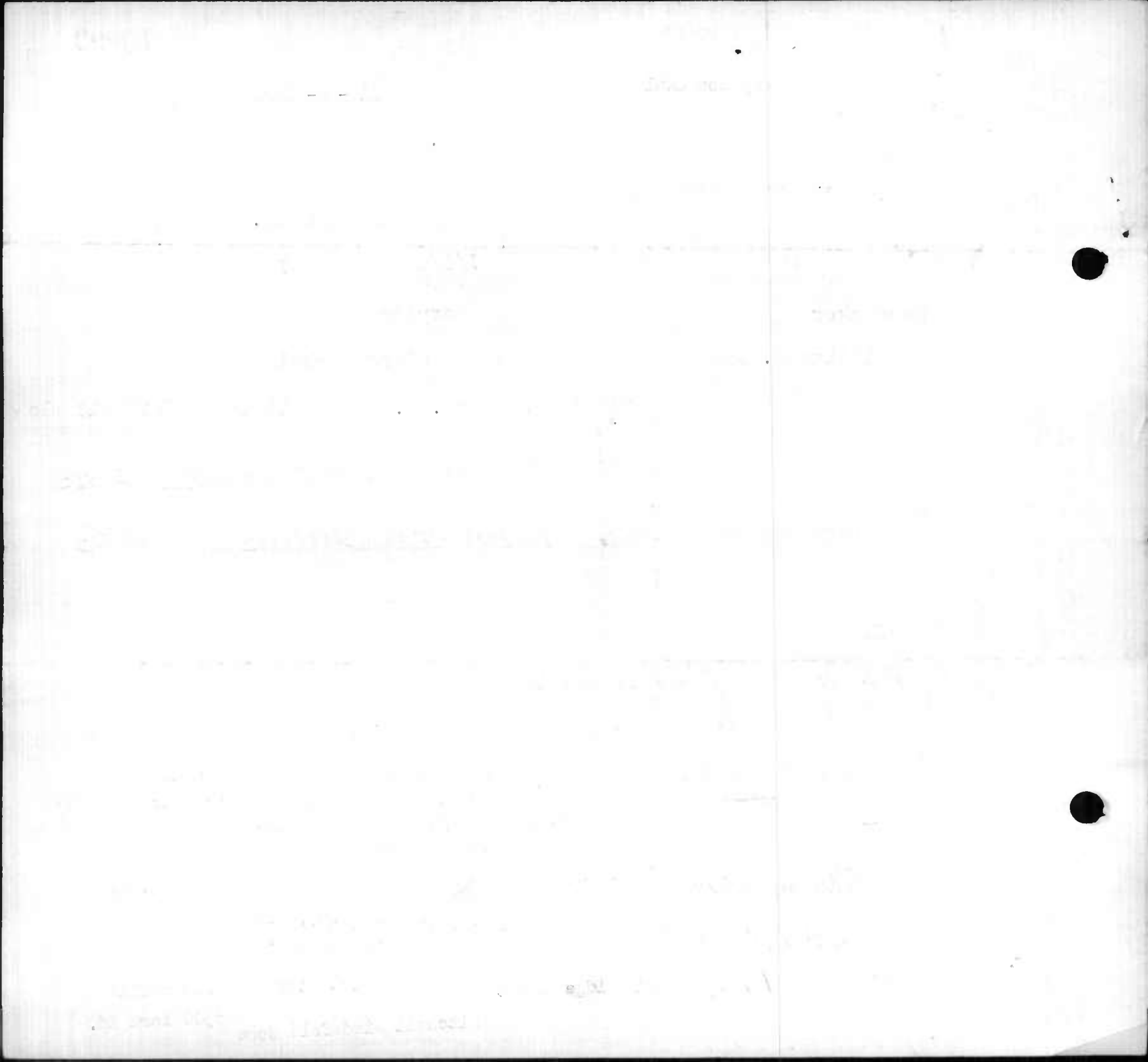
1. NAME OF DECEASED (Type or Print) ELIZABETH DIETRICH		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Nov. 3, 1971		3. DATE PRONOUNCED DEAD Month Day Year Hour November 3, 1971 10:17 A.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4401 Roland Avenue, Apt. 611		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2714			
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH July 28, 1907	10. AGE (In years last birthday) 64	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 4401 Roland Avenue, Apt. 611		
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert E. Tubman	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Maude Eugenia Skinner	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT Wineholt ADDRESS Mrs. C. Herbert Jr. 6306 Pinehurst Road	
19. 571.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Fatty metamorphosis of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes (Partial)	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> (partial) Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. DATE SIGNED 11/3/71 EXAMINER'S NAME (Type)					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/5/71		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery	
		24D. LOCATION (City, town, or county) (State) Pikesville, Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld 6500 York Road	

VS 151-REV. 1/1/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

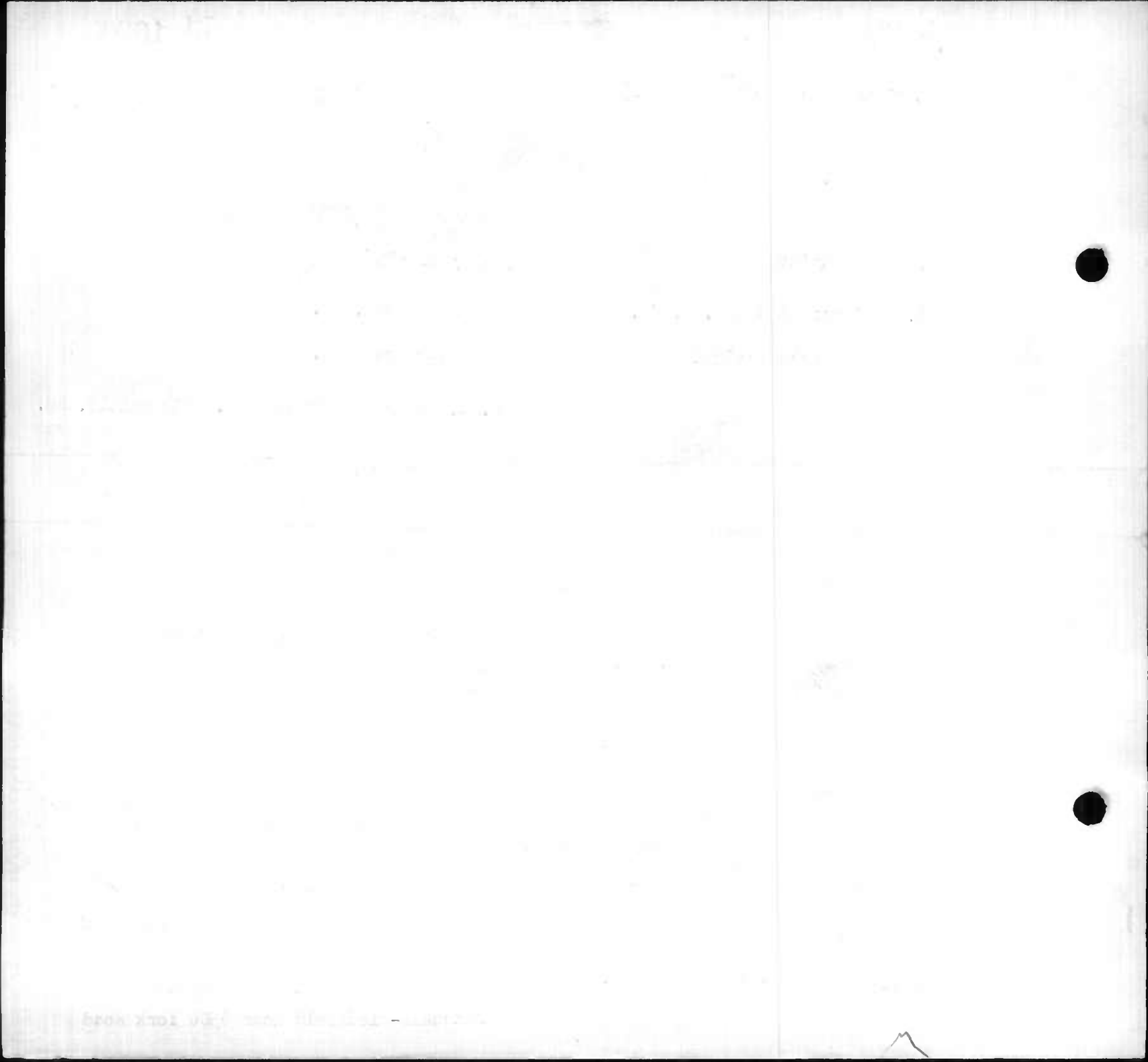
K-400 71 10299		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 10299	
1. NAME OF DECEASED (Type or Print) Mary Roe Kahl		2. DATE AND HOUR OF DEATH 11 - 4 - 1971			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Long Green Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2714			
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4622 Wilmslow Rd.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/5/1884	9. AGE (In years lost birthday) 87
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William H. Roe		14. MOTHER'S MAIDEN NAME Clara Raybold			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 26 20 4700		17. INFORMANT Mrs. J. Lloyd Wilkinson	
				ADDRESS 4622 Wilmslow	
18. 412,317-882 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC HEART DISEASE		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEREBRAL ARTERIOSCLEROSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MOS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) 10 YRS			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 8-30-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FRAC. RT FEMUR		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) BALTO CITY	
21D. TIME OF INJURY (APPROX.) AUG 17 1971 8am		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? HAD A STROKE AND FELL	
22. I certify that (I) (We) attended the deceased from SEP 3 1971 to NOV 3 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John M. Scott		23B. DATE SIGNED 11/4/71			
23C. PHYSICIAN'S NAME (Type) JOHN M. SCOTT		23D. ADDRESS 600 W. NORTHERN PARKWAY BALTO MD 21210			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/6/71		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
		24D. LOCATION (City, town, or county) (State) Reistertown Rd Pikesville Md			
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Sabej, M.D.		25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home	
				ADDRESS 6500 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10300	
V-424 71 10300		BIRTH NO. 71 10300	
1. NAME OF DECEASED (Type or Print) VOELKEL, John W.		2. DATE AND HOUR OF DEATH 11-3-71 11:20 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY 2758	
5. SEX Male		6. RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-12-90	
9. AGE (In years last birthday) 81		10. UNDER 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Engineer B & O R. R. Co.		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Voelkel		14. MOTHER'S MAIDEN NAME Barbara A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT J. C. Voelkel		ADDRESS 5 Durbane Ct. Lutherville, Md.	
18. 44191 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Ruptured aortic aneurysm DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Incarcerated, left ing. Hernia			
19A. DATE OF OPERATION 10-28-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Incarcerated, left ing. Hernia	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. HOW DID INJURY OCCUR?	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10-28-71 to 11-3-71 that (I) (we) last saw the deceased alive on 11-3-71 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Michael P. Buckness M.D.		23B. DATE SIGNED 11-3-71	
23C. PHYSICIAN'S NAME (Type) Michael P. Buckness		23D. ADDRESS Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/6/71	
24C. NAME of CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		ADDRESS 6500 York Road	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 10301</u>	
BIRTH NO. <u>S-632 71 10301</u>		1. NAME OF DECEASED (Type or Print) <u>Swartz, Gretchen V.</u>		2. DATE AND HOUR OF DEATH <u>11/4/71 204 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>CARROLL</u> C. CITY OR TOWN <u>SYKESVILLE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>RT 4 Box 319</u> <u>21784</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-71</u>		9. AGE (In years last birthday) <u>XX</u>	If Under 1 Yr. Months Days Hours Min. <u>1</u> <u>9</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <u>Harry Swartz</u>				
14. MOTHER'S MAIDEN NAME <u>SHARON Weetenkamp</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>				
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Mr. Harry Swartz</u> Route 4 Box 319 Sykesville, Maryland 21784				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Congenital Heart Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cardiovascular Arrest</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>None</u>							
19A. DATE OF OPERATION <u>2/1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>11/4/71</u> to <u>11/4/71</u> that (2) (we) last saw the deceased alive on <u>11/4/71</u> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>James E. Robotham M.D.</u>				23B. DATE SIGNED <u>11/4/71</u>		23C. PHYSICIAN'S NAME (Type) <u>James E. Robotham M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/8/1971</u>		24C. NAME of CEMETERY or CREMATORY <u>Lake View Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Sykesville, Md. Carroll County</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR 8728 Liberty Road ADDRESS <u>Loring Byers Funeral Directors, P. A. 21133</u>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 10302	
BIRTH NO. 71 10302				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ROBINSON, Marshall Clarence			2. DATE AND HOUR OF DEATH (Nov. 6, 1971) 11-6-71 2:50 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Harford Co. C. CITY OR TOWN Bel Air D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1319 Plymouth Road		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (Mo., Yr., Day) 12-1-10	9. AGE (In years last birthday) 60	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver			10B. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) Harford Co. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Clarence Robinson		
14. MOTHER'S MAIDEN NAME Laura Hecht			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6-19-42 to 9-27-43		
16. SOCIAL SECURITY NO. 217-07-94-31			17. INFORMANT VA Hospital Records ADDRESS Baltimore, Maryland 21218		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MYOCARDIAL INFARCTION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 11-5- 19 71 to 11-6- 19 71 , that (X) (we) last saw the deceased alive on 11-6- 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) not view the body after death.					
23A. SIGNATURE Marshall M. Urish M.D.				23B. DATE SIGNED 6 NOV 1971	
23C. PHYSICIAN'S NAME (Type) MARSHALL M. URIST, M.D.				23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov. 9, 1971		24C. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	
24D. LOCATION (City, town, or county) (State) Bel Air, Harford Co., Maryland 21014		25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Joseph William Foster			
25D. ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014					

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FUNERAL DIRECTOR: IMPORTANT

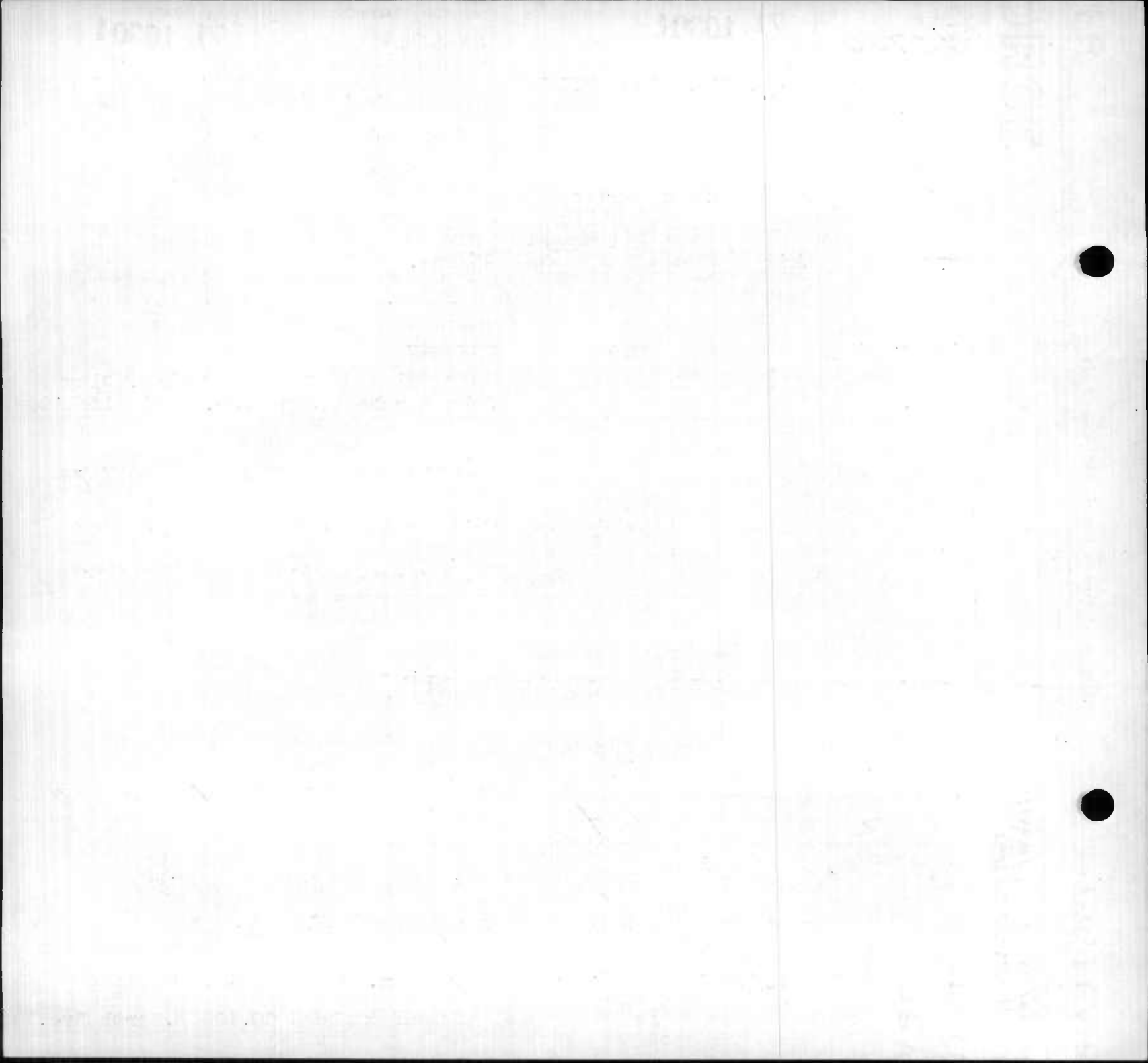
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-635 71 10303				CITY HEALTH DEPARTMENT		REG. NO. 71 10303	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HARTMAN, AMELIA H.				2. DATE AND HOUR OF DEATH NOVEMBER 5, 1971 (9:25 P.M.)			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE, MARYLAND 21229				A. STATE MARYLAND B. COUNTY HOWARD COUNTY			
C. CITY OR TOWN BALTIMORE City				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 3091 Rogers Av. Ellicott City				G/O-R.B. HAMILTON, BOX-686, RT-#5			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1886		9. AGE (In years last birthday) 85	10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JAMES HAMILTON			
14. MOTHER'S MAIDEN NAME EVA (BARNITZ)				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 216-46-0281				17. INFORMANT BALTO. MD. 21229			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				19. DATE OF OPERATION 2			
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 4 19 71 to NOVEMBER 5 19 71 that (I) (we) last saw the deceased alive on NOVEMBER 5 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Donato A. Vargas Jr.</i> M.D. DEGREE				23B. DATE SIGNED 11-6-71		23C. PHYSICIAN'S NAME (Type) DONATO VARGAS, M.D.	
23D. ADDRESS ST AGNES HOSPITAL				24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 11/9/1971				24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 8 1971				25B. NAME OF REGISTRAR <i>Robert E. Talley, M.D.</i>		25C. FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North av.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

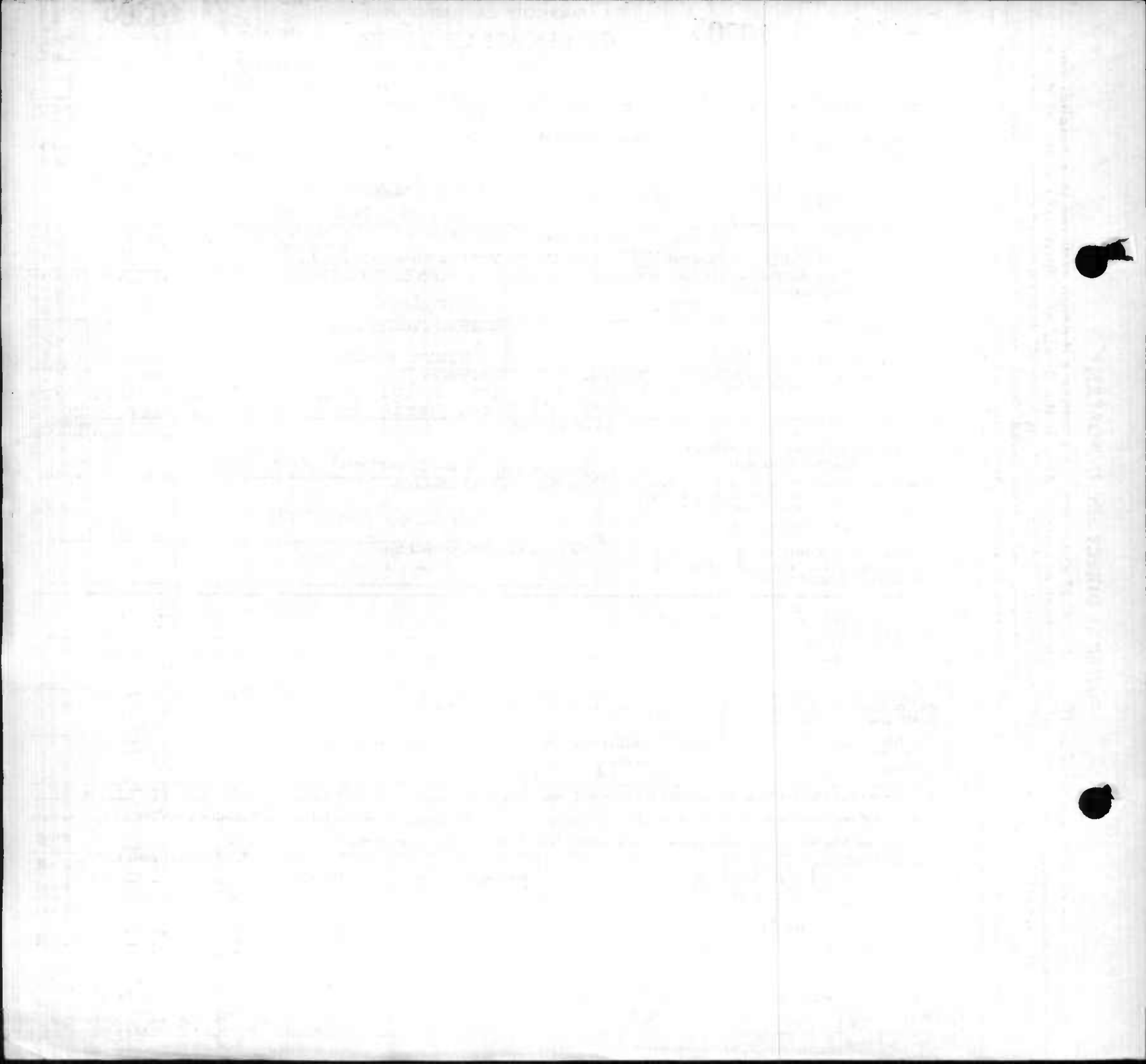
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 10304	
7-420 71 10304				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FRANCES ALENA ZELWIS		11-7-71 8 am M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
00 2005 Denison Street 21216				Maryland 1102	
5. SEX		6. RACE		C. CITY OR TOWN	
Female		White		Baltimore	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years, last birthday)		E. STREET AND NUMBER	
25/Dec./1892		79		824 Park Avenue	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
NONE				LITHUANIA	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?	
				USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
(UNKNOWN) STEIN				UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
NO					
17. INFORMANT: Atty - Bldg. City 1				ADDRESS	
John Marshall Jones, Jr. 1403 Fidelity					
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				3 days	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES				Unknown	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				5 days	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/2 1971 to 11/4 1971, that (I) (we) last saw the deceased alive on 11/4 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
E.E. Holt M.D.				11/8/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
E.E. Holt, M.D.				3715 Liberty Hts. Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		10/Nov/71		Baltimore National Cem. Catonsville, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 8 1971		Robert E. Jones, M.D.		STEWART & MOWEN CO. 108 W. North Ave. 1	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-000 71 10305				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 10305	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Annie C. Seay</u>				2. DATE AND HOUR OF DEATH <u>November 2, 1971</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1607</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital of Baltimore</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3121 Brighton Street</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-6-1894</u>	9. AGE (In years last birthday) <u>77</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Pvt. Family</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>James Edward Tabbs</u>				14. MOTHER'S MAIDEN NAME <u>Laura Shorts</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-32-2483</u>		17. INFORMANT ADDRESS <u>Mrs. Sylvia Martin 2822 Presstman Street</u> <u>Mrs. Marie Brown 3121 Brighton Street</u>	
18. <u>1971-8-1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Liver</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cachexia / Metastatic</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cachexia / Metastatic</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Amuria</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Amuria</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Amuria</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11-1-1971</u> to <u>11-2-1971</u> that (I) (we) last saw the deceased alive on <u>11-2-1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ratit</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11-5-1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>KHUSHAL D. PATIL</u>				23D. ADDRESS <u>SINAI HOSPITAL OF BALTIMORE, INC.</u> <u>Belvedere Ave. at Greenspring, Baltimore</u> <u>MD 21215</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-6-1971</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Calvary Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Co. Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1971</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> T-460 71 10306 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 10306	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Bessie Clark Taylor		November 1, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE B. COUNTY		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			Maryland		
46 Lutheran Hospital			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			1829 Presstman Street		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Female	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2-19-1921	50	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Nurses Aid		Providence Hospital		Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Rev. Moses Prophet Clark			USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			213-20-0596		Bessie E. Chambers 1829 Presstman St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Chronic glaucoma		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Diabetes		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nearly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from Jan 1971 to Oct 1971 and that (1) (we) last saw the deceased alive on Oct 10 1971 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (dtd) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Robert Levy				11/5/71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Robert Levy		M. D. 114 Medical Arts Building			
24A. BURIAL CREMATION, REMOVAL (Specify)		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Mt. Calvary Cemetery		Anne Arundel Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 8 1971		Robert E. Taylor, M.D.		NUTTER FUNERAL HOME 3035 W. NORTH AVE.	

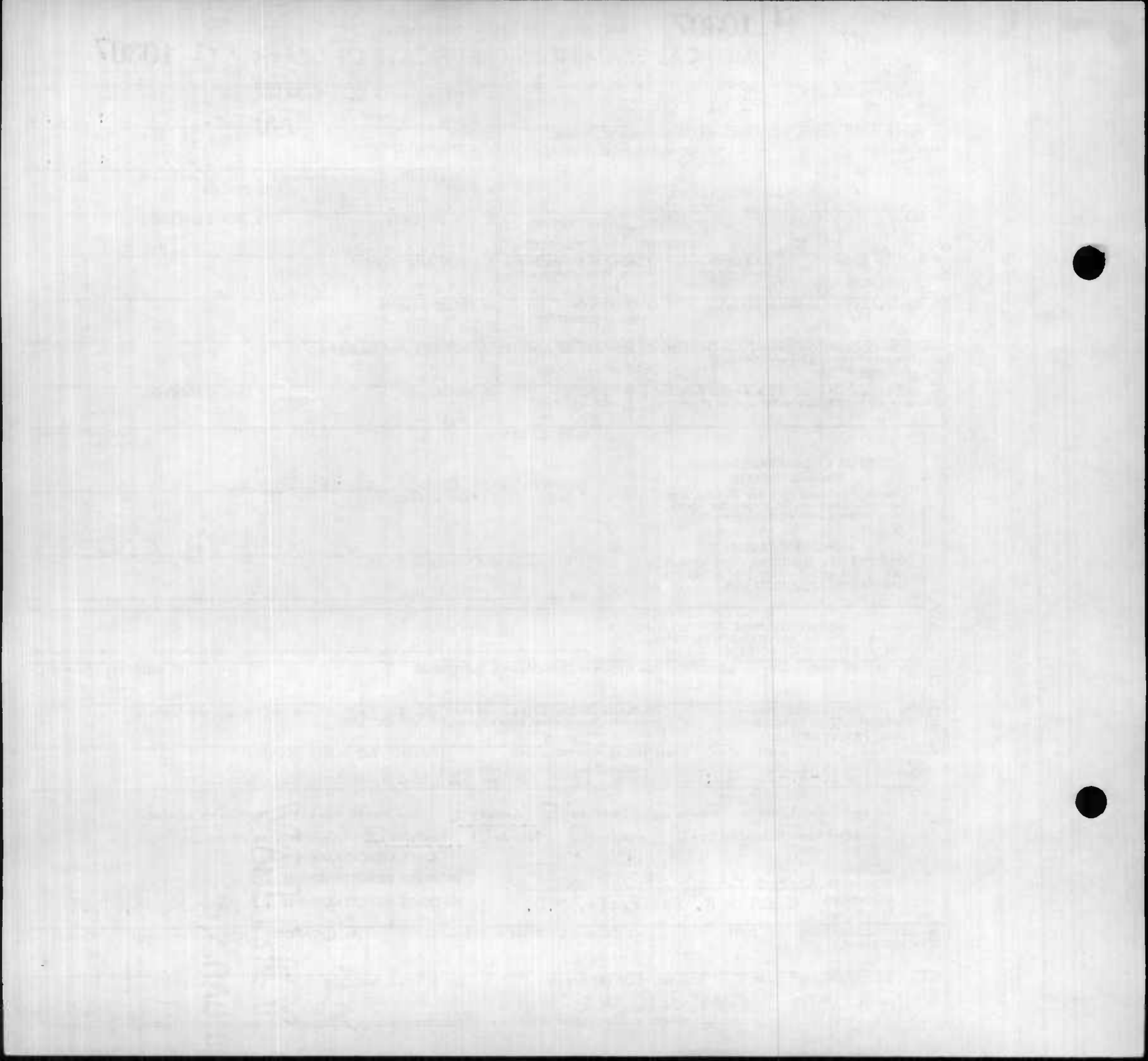
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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		VIOLA MORTON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour November 4, 1971 1:10 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Sinai Hospital		3. DATE PRONOUNCED DEAD		Month Day Year Hour November 4, 1971 1:10 A. M.	
6. SEX		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2716	
Female		Negro		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
1-24-1914		57		Virginia		USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME		13. FATHER'S NAME	
custodian		School System		Willia Ann Layton		Eli F. Carter	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
No		220-30-0721		Artist Morton		2803 Virginia Avenue	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
E9651X		(A) IMMEDIATE CAUSE Gunshot wound of abdomen DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)			
2				Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
		House		27-16			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED.		22F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour) 10-17-71 12:00 P.m.		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Shot during altercation			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		November 4, 1971	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11-8-1971		Arbutus Memorial Park		Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 8 1971		Robert E. Jaber, M.D.		NUTTER FUNERAL HOME		3035 W. NORTH AV	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

MK

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 10308</u>	
7-432 71 10308		CERTIFICATE OF DEATH	
BIRTH NO. <u>7-432</u>		2. DATE AND HOUR OF DEATH <u>NOVEMBER 2, 1971</u> <u>8:45 P.</u>	
1. NAME OF DECEASED (Type or Print) <u>FIELDS, HELEN VIRGINIA</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST. AGNES HOSPITAL</u> CATON & WILKENS AVE		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>FEMALE</u> 6. RACE <u>NEGRO</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>1921 NORTH EAST AVENUE</u> <u>21227</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		8. DATE OF BIRTH <u>02 19 87</u> 9. AGE (In years last birthday) <u>84</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>PVT. FAMILY</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>JAMES TABBS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. MOTHER'S MAIDEN NAME <u>LAURA SHORTS</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>217 56 4307</u>		17. INFORMANT <u>MISS DOROTHY FIELDS</u> ADDRESS <u>1921 NORTHEAST AVE</u>	
18. <u>393X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Fibrous Pericarditis, marked</u> [This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Coronary atherosclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>X</u> (this hospital) attended the deceased from <u>OCTOBER 29</u> 19 <u>71</u> to <u>NOVEMBER 2</u> 19 <u>71</u> that <u>X</u> (we) last saw the deceased alive on <u>NOVEMBER 2</u> 19 <u>71</u> and that in <u>X</u> (our) opinion death occurred on the date and hour and from the causes stated above. (U) (We) (did) <u>XXXXXX</u> view the body after death.			
23A. SIGNATURE <u>Robert E. Fisher, M.D.</u>		23B. DATE SIGNED <u>11.3.71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert E. Fisher, M.D.</u>		23D. ADDRESS <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-6-71</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 8 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	
25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE.</u>		25D. ADDRESS	

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27942-19142

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|--|
| H-620 71 10309                                                                                                                                                                                                                                                                                                                     |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                         |  | REG. NO. 71 10309                                                                                                   |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                          |  | 1. NAME OF DECEASED<br>(Type or Print) <i>Phyllis Harris (Gans)</i>                                                                                      |  | 2. DATE AND HOUR OF DEATH<br><i>11/8/71 10:00 am</i>                                                                |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>806</i>                   |  |                                                                                                                     |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Johns Hopkins Hospital</i>                                                                                                                                                                                                                                                              |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                     |  | C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX <i>Female</i> 6. RACE <i>Colored</i>                                                                                                                                                                                                                                                                                        |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <i>9/25/56</i> 9. AGE (In years last birthday) <i>15</i>                                           |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                        |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                        |  | 11. BIRTHPLACE (State or foreign country)                                                                           |  |
| 13. FATHER'S NAME<br><i>Larry Harris</i>                                                                                                                                                                                                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br><i>Moratty Jones</i>                                                                                                         |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)            |  |
| 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                            |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                                                                             |  |
| 18. <i>E95013</i>                                                                                                                                                                                                                                                                                                                  |  | CAUSE OF DEATH                                                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                        |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                     |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                   |  | <i>? PULMONARY EMBOLUS 1 hr</i>                                                                                     |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                     |  | (B) <i>INGESTION OF UNKNOWN AMT. TYPE 60 hrs</i><br>DUE TO, OR AS A CONSEQUENCE OF <i>OF DRUGS</i>                                                       |  |                                                                                                                     |  |
| (C) <i>ADOLESCENT ADJUSTMENT REACTION 3 yrs</i>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                     |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                   |  | <i>none</i>                                                                                                                                              |  |                                                                                                                     |  |
| 19A. DATE OF OPERATION<br><i>2</i>                                                                                                                                                                                                                                                                                                 |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  | 20A. AUTOPSY? (Yes or No) <i>Yes</i>                                                                                |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                              |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <i>Home</i>                                                      |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>1623 Lanning Ave 8-06</i>               |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>11/5/71 7 pm</i>                                                                                                                                                                                                                                                      |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR? <i>Drug Ingestion took overdose</i>                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11/5/71</i> to <i>11/8/71</i> and that (I) (we) last saw the deceased alive on <i>11/8</i> 19 <i>71</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                                          |  |                                                                                                                     |  |
| 23A. SIGNATURE<br><i>SD Wright M.D.</i>                                                                                                                                                                                                                                                                                            |  | 23B. DATE SIGNED<br><i>11/8/71</i>                                                                                                                       |  | 23C. PHYSICIAN'S NAME (Type)                                                                                        |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                           |  | 24B. DATE                                                                                                                                                |  | 24C. NAME of CEMETERY or CREMATORY                                                                                  |  |
| <i>Burial</i>                                                                                                                                                                                                                                                                                                                      |  | <i>11/11/71</i>                                                                                                                                          |  | <i>Mt Auburn Cemetery</i>                                                                                           |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 9 1971</i>                                                                                                                                                                                                                                                                               |  | 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor, M.D.</i>                                                                                                  |  | 25C. FUNERAL DIRECTOR<br><i>Lawton R. Carroll</i>                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                          |  | ADDRESS<br><i>1529 E. ...</i>                                                                                       |  |

James Oliver

Weatherly Jones  
1/22/20 10  
1023-6231  
encl

David Hoover

5. 60 cm diameter 26509 m3



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                     |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Oliver F. Roberts</b><br>(Coleman)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>11 5 71 8:30 a.m.</b> |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>37 Mercy Hospital</b><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>11 5 71 8:30 a.m.</b>                                                                          |  |
| 6. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 7. RACE<br><b>Negro</b>                                                                                                                             |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>1802</b>                  |  |
| 9. DATE OF BIRTH<br><b>Aug 29, 1920</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10. AGE (In years last birthday)<br><b>51</b>                                                                                                       |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Queen Anne Co., Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. CITIZEN OF<br><b>U.S.A.</b>                                                                                                                     |  |
| 13. FATHER'S NAME<br><b>William Howard Roberts</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 14. STREET AND NUMBER<br><b>106 N. Carrollton Avenue</b>                                                                                            |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Franklin Realty</b>                                                                                         |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Edith Rosman Wilson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>yes 8-3-42, 1-6-46</b>                |  |
| 17. SOCIAL SECURITY NO.<br><b>216-14-2982</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 18. INFORMANT P.O. Box 73, Wye Address Mills, Md.<br><b>Mrs. Ollie Mae Price 21679</b>                                                              |  |
| 19. <b>E814.7</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Fracture of base of skull</b><br>CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                        |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                    |  |
| 21. AUTOPSY? (Yes or No)<br><b>yes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                     |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>STREET</b>                                           |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>Franklin Street + cathedral 401</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                     |  |
| 22D. TIME (Month) (Day) (Year) (Hour) (Approx.)<br><b>11 5 71 8:20 a.m.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                   |  |
| 22F. HOW DID INJURY OCCUR?<br><b>Subject pedestrian hit by auto.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                     |  |
| 23.<br>I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Peter Lipkovic</b> M.D.<br>EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b><br>DATE SIGNED <b>11/5/71</b> |  |                                                                                                                                                     |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 24B. DATE<br><b>11-9-71</b>                                                                                                                         |  |
| 24C. NAME of CEMETERY or CREMATORY<br><b>John Wesley</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Carmichael, Maryland</b>                                                                        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 9 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Faber, M.D.</b>                                                                                              |  |
| 25C. FUNERAL DIRECTOR<br><b>1735 Harford Ave. 21213</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 25D. NAME OF FUNERAL HOME<br><b>Marshall W. Jones, Jr.</b>                                                                                          |  |

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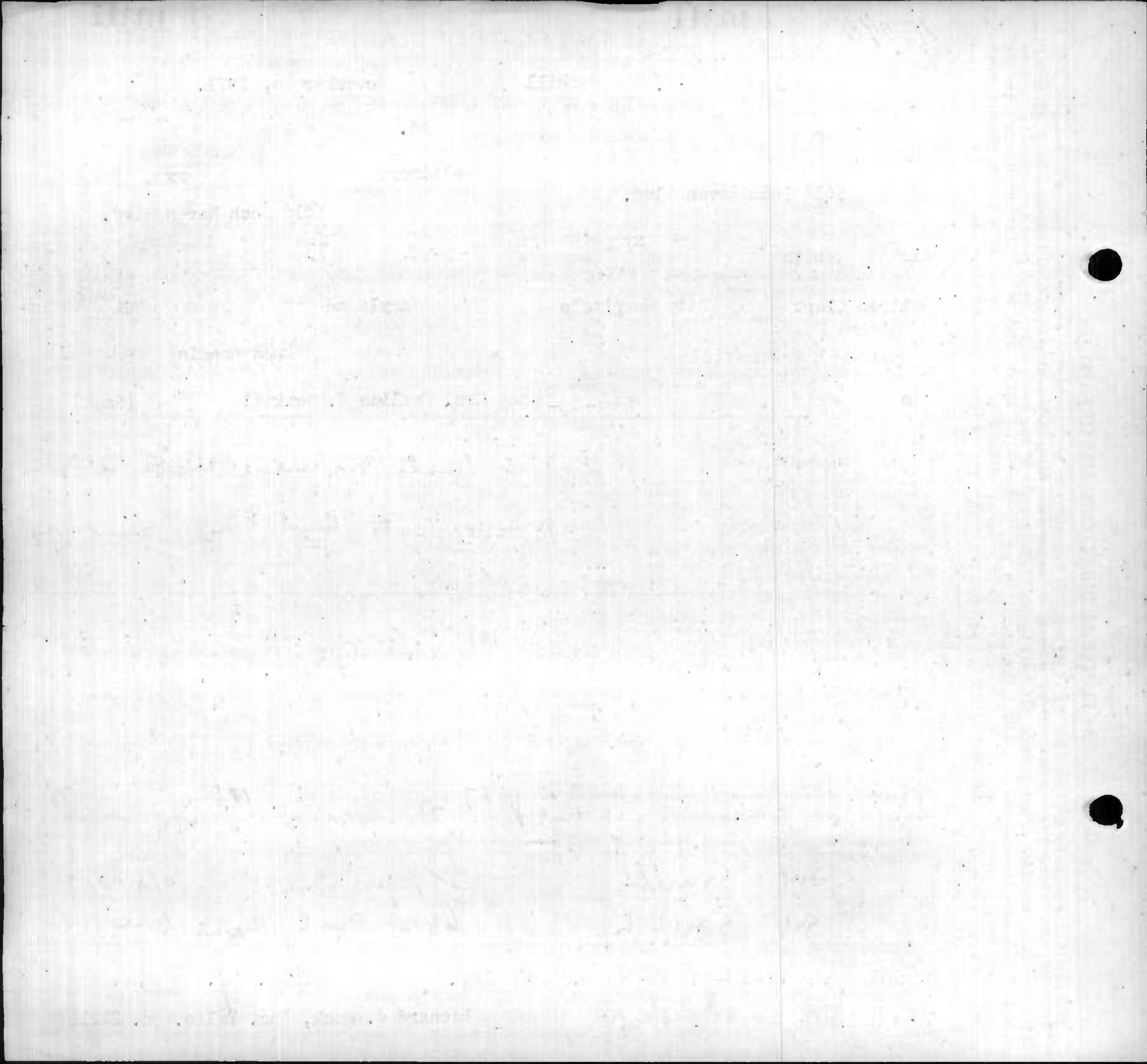
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

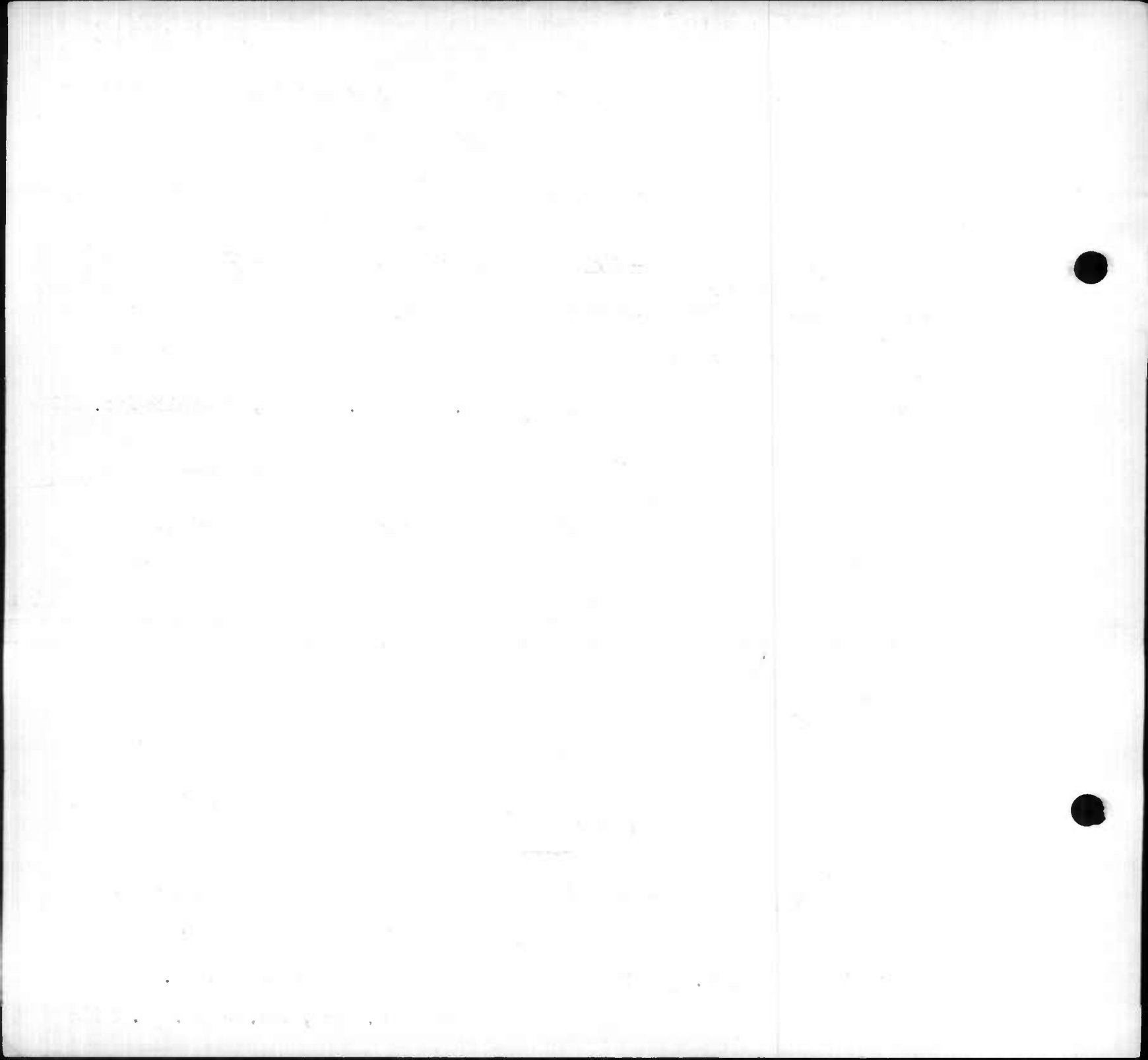
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                                                                                     |                                   | REG. NO. <b>71 10311</b>                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------------------------------------------------------------|
| M-240 10311                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                                                                                     |                                   | CERTIFICATE OF DEATH                                                                          |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                            |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>Francis X. Meskill</b>                                                                                                                                                    |                                   | 2. DATE AND HOUR OF DEATH<br><b>November 6, 1971. 12:30 a.m.</b>                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                               |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>2748</b>                                                                                  |                                   |                                                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>00 5616 Loch Raven Blvd.</b>                                                                                                                                                                                                                                                                                              |                         | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                                                                 |                                   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                      |                         | E. STREET AND NUMBER<br><b>5616 Loch Raven Blvd.</b>                                                                                                                                                                |                                   |                                                                                               |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                | 6. RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                         | 8. DATE OF BIRTH<br><b>7-6-98</b> | 9. AGE (In years last birthday)<br><b>73</b>                                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Clerk</b>                                                                                                                                                                                                                                                  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>City Hospitals</b>                                                                                                                                                          |                                   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                  |
| 13. FATHER'S NAME<br><b>Michael J Meskill</b>                                                                                                                                                                                                                                                                                                                        |                         | 14. MOTHER'S MAIDEN NAME<br><b>Anna Manning</b>                                                                                                                                                                     |                                   |                                                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                |                         | 16. SOCIAL SECURITY NO.<br><b>216-03-3952</b>                                                                                                                                                                       |                                   | 17. INFORMANT<br><b>Mrs. Pauline E. Meskill</b>                                               |
|                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                                                                                     |                                   | ADDRESS<br><b>(Same)</b>                                                                      |
| 18. <b>410.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                         | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute myocardial infarct. 2 hrs</b><br>(B) <b>Intermittent Heart Dis</b> DUE TO, OR AS A CONSEQUENCE OF: <b>several years</b><br>(C) _____ |                                   |                                                                                               |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                    |                                   | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No                              |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                              |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                            |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                            |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                           |                                   | 21F. HOW DID INJURY OCCUR?                                                                    |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1967</b> to <b>10/6</b> 19 <b>71</b> , that (I) (we) last saw the deceased alive on <b>oct 6</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                          |                         |                                                                                                                                                                                                                     |                                   |                                                                                               |
| 23A. SIGNATURE<br><b>Sol Smith</b>                                                                                                                                                                                                                                                                                                                                   |                         | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>                                                                                     |                                   | 23B. DATE SIGNED<br><b>11/8/71</b>                                                            |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Sol Smith</b>                                                                                                                                                                                                                                                                                                                     |                         | 23D. ADDRESS<br><b>6810 Park Heights Ave Balto Md</b>                                                                                                                                                               |                                   |                                                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                            |                         | 24B. DATE<br><b>11-10-71</b>                                                                                                                                                                                        |                                   | 24C. NAME OF CEMETERY or CREMATORY<br><b>New Cathedral Cem.</b>                               |
|                                                                                                                                                                                                                                                                                                                                                                      |                         | 24D. LOCATION<br><b>Balto. Md.</b>                                                                                                                                                                                  |                                   | (City, town, or county) (State)                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 9 1971</b>                                                                                                                                                                                                                                                                                                                 |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>                                                                                                                                                             |                                   | 25C. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>                        |
|                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                                                                                     |                                   | ADDRESS                                                                                       |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                          |                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                |                  | REG. NO. <b>71 10312</b>                                                                                                                                 |                                           |
| M-655 71 10312                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                                          |                                           |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                      |                  | 2. DATE AND HOUR OF DEATH                                                                                                                                |                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARMION, JESSIE H.</b>                                                                                                                                                                                                                                                               |                  | <b>6 NOV 71 7 45 P M.</b>                                                                                                                                |                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                         |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                    |                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>MONTEBELLO STATE HOSP</b>                                                                                                                                                                                      |                  | A. STATE <b>Md.</b> B. COUNTY <b>21218</b>                                                                                                               |                                           |
|                                                                                                                                                                                                                                                                                                                                |                  | C. CITY OR TOWN <b>Balto</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |                                           |
|                                                                                                                                                                                                                                                                                                                                |                  | E. STREET AND NUMBER <b>3633 Old York Rd.</b>                                                                                                            |                                           |
| 5. SEX <b>F</b>                                                                                                                                                                                                                                                                                                                | 6. RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Dec 7, 1922</b>       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Manager Manager</b>                                                                                                                                                                                                          |                  | 10B. KIND OF BUSINESS OR INDUSTRY <b>Cambels-Aldens</b>                                                                                                  | 9. AGE (in years last birthday) <b>48</b> |
| 13. FATHER'S NAME <b>Harry H rman</b>                                                                                                                                                                                                                                                                                          |                  | 14. MOTHER'S MAIDEN NAME <b>Georgianna Reed</b>                                                                                                          |                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                          |                  | 16. SOCIAL SECURITY NO. <b>217-14-9184</b>                                                                                                               |                                           |
| 17. INFORMANT <b>Mr. Robert P. Marmion, 3200 White Ave. 21214</b>                                                                                                                                                                                                                                                              |                  | ADDRESS                                                                                                                                                  |                                           |
| 18. <b>182-7 I</b> CAUSE OF DEATH                                                                                                                                                                                                                                                                                              |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |                                           |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinoma Uterus</b>                                                                                                      |                  | <b>1 year</b>                                                                                                                                            |                                           |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                 |                  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>with Metastases to Lung and Brain</b>                                                          |                                           |
|                                                                                                                                                                                                                                                                                                                                |                  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                      |                                           |
|                                                                                                                                                                                                                                                                                                                                |                  | (C) _____                                                                                                                                                |                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                         |                  |                                                                                                                                                          |                                           |
| 19A. DATE OF OPERATION <b>0</b>                                                                                                                                                                                                                                                                                                |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                           |
| 20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                 |                  | 20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                 |                                           |
| 21A. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                      |                  | 21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                 |                                           |
| 21C. INJURY OCCURRED                                                                                                                                                                                                                                                                                                           |                  | 21D. HOW DID INJURY OCCUR?                                                                                                                               |                                           |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                              |                  |                                                                                                                                                          |                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Oct 14, 1971</b> to <b>Nov 6, 1971</b> that (I) (we) last saw the deceased alive on <b>Nov 6, 1971</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. |                  |                                                                                                                                                          |                                           |
| 23A. SIGNATURE <b>Fredrick N. Pearson MD</b>                                                                                                                                                                                                                                                                                   |                  | 23B. DATE SIGNED <b>Nov 6, 71</b>                                                                                                                        |                                           |
| 23C. PHYSICIAN'S NAME (Type) <b>FREDERICK N. PEARSON, MD</b>                                                                                                                                                                                                                                                                   |                  | 23D. ADDRESS <b>Montebello State Hospital</b>                                                                                                            |                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                         |                  | 24B. DATE <b>11/10/71</b>                                                                                                                                |                                           |
| 24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>                                                                                                                                                                                                                                                               |                  | 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>                                                                                      |                                           |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1971</b>                                                                                                                                                                                                                                                                              |                  | 25B. NAME OF REGISTRAR <b>Robert E. Taylor, Md.</b>                                                                                                      |                                           |
| 25C. FUNERAL DIRECTOR <b>Leona rd J. Ruck, Inc. Balto. Md. 21214</b>                                                                                                                                                                                                                                                           |                  | ADDRESS                                                                                                                                                  |                                           |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                                                                                                                                                                                   |                              |                                                                            |                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------|
| S-126 71 10313                                                                                                                                                                                                                                                                                                                                                                                                        |                  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                          |                              | X<br>REG. NO. 71 10313                                                     |                                                           |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                             |                  | 1. NAME OF DECEASED<br>(Type or Print) <i>Francis William Spicer</i>                                                                                                                                                                                                                                              |                              | 2. DATE AND HOUR OF DEATH<br>11-06-71 19:45 A.M.                           |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 11-16-71<br><b>CERTIFICATE AMENDED</b><br>33 THE JOHNS HOPKINS HOSPITAL<br>BALTIMORE, MD 21205                                                                                                                                                                                         |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE MARYLAND B. COUNTY ANNE ARUNDEL 5200<br>C. CITY OR TOWN GLEN BURNIE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER 238 WOODHILL DRIVE APT E |                              |                                                                            |                                                           |
| 5. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                        | 6. RACE<br>WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                       | 8. DATE OF BIRTH<br>03-27-22 | 9. AGE (In years last birthday)<br>49                                      | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Teacher                                                                                                                                                                                                                                                                                                                |                  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                 |                              | 11. BIRTHPLACE (State or foreign country)<br>Boston, Mass.                 |                                                           |
| 13. FATHER'S NAME<br>BOLE SPICER                                                                                                                                                                                                                                                                                                                                                                                      |                  | 14. MOTHER'S MAIDEN NAME<br>Elizabeth<br>-CHARLOTTE SAWYER                                                                                                                                                                                                                                                        |                              | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                        |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>--No- Yes U.S. Army 1942-1946                                                                                                                                                                                                                                                                             |                  | 16. SOCIAL SECURITY NO.<br>Unk--                                                                                                                                                                                                                                                                                  |                              | 17. INFORMANT<br>Mrs. Ann S. Cort, 2905 Woodstock Ave. Silver Springs, Md. |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>S.S.#028-16-5453<br>Hodgkin's disease<br>12 years<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>Hodgkin's disease                                                                                                                                                                                                                                          |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 years                   |                                                           |
| 19A. DATE OF OPERATION<br>2                                                                                                                                                                                                                                                                                                                                                                                           |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                  |                              | 20A. AUTOPSY? (Yes or No)<br>YES                                           |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                 |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                          |                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                                           |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                          |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                         |                              | 21F. HOW DID INJURY OCCUR?                                                 |                                                           |
| 22. I certify that (1) (this hospital) attended the deceased from Nov. 1, 1971 to Nov. 6, 1971 that (1) (we) lost saw the deceased alive on Nov. 6, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.                                                                                                     |                  |                                                                                                                                                                                                                                                                                                                   |                              |                                                                            |                                                           |
| 23A. SIGNATURE<br><i>Thomas K. Hodous, M.D.</i>                                                                                                                                                                                                                                                                                                                                                                       |                  | 23B. DATE SIGNED<br>Nov. 6, 1971                                                                                                                                                                                                                                                                                  |                              | 23C. PHYSICIAN'S NAME (Type)<br>THOMAS K. HODOUS M.D.                      |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Cremation                                                                                                                                                                                                                                                                                                                                                                 |                  | 24B. DATE<br>11/9/71.                                                                                                                                                                                                                                                                                             |                              | 24C. NAME OF CEMETERY OR CREMATORY<br>Greenmount Crematory                 |                                                           |
| 24D. LOCATION<br>Baltimore, Md.                                                                                                                                                                                                                                                                                                                                                                                       |                  | 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 9 1971                                                                                                                                                                                                                                                                     |                              | 25B. NAME OF REGISTRAR<br>Chas E. Jaber, M.D.                              |                                                           |
| 25C. FUNERAL DIRECTOR<br>Leona rd J. Ruck, Inc. Balto. Md. 21214                                                                                                                                                                                                                                                                                                                                                      |                  | 25D. ADDRESS                                                                                                                                                                                                                                                                                                      |                              | 25E. ADDRESS                                                               |                                                           |

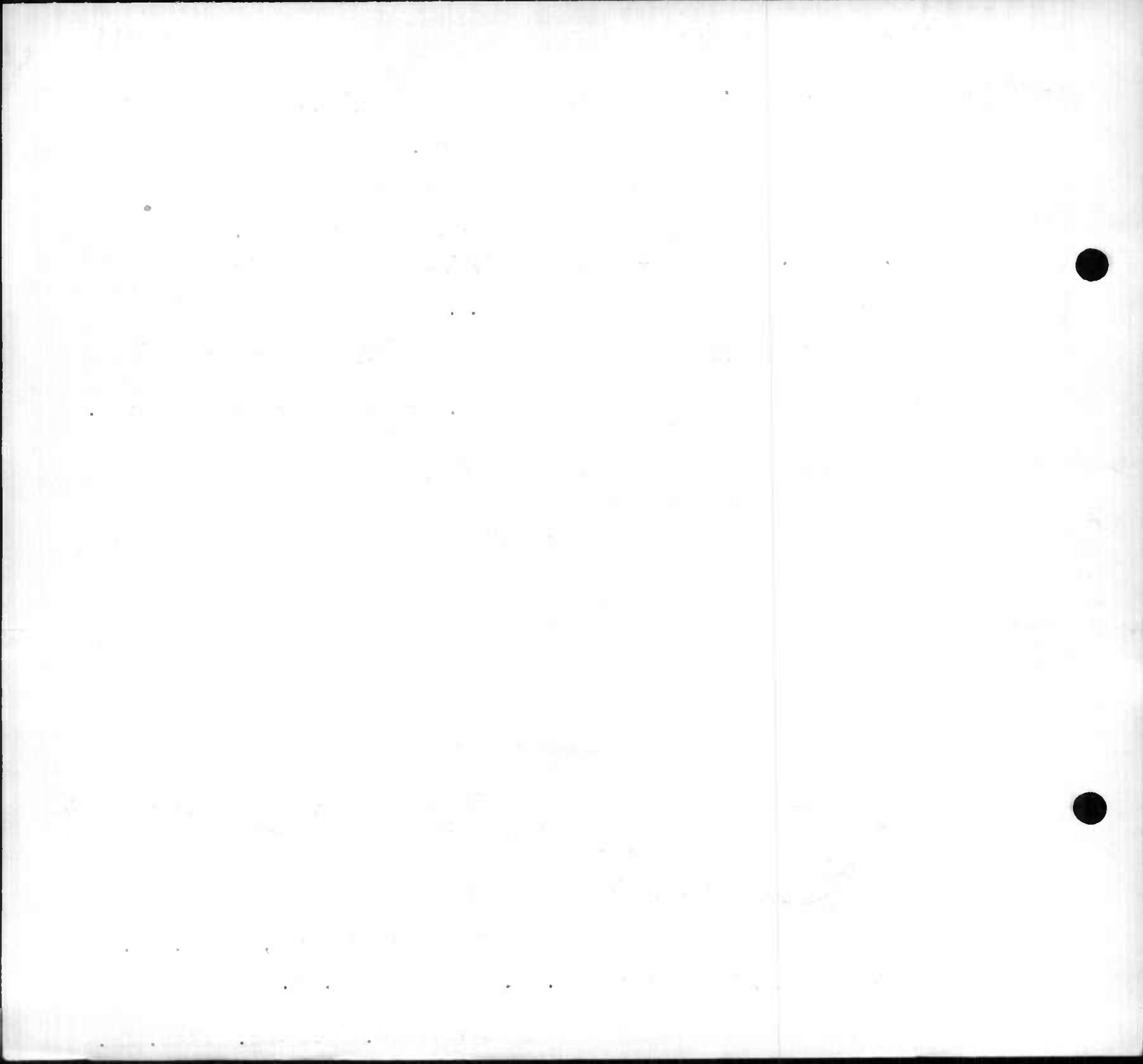




# FUNERAL DIRECTOR: IMPORTANT

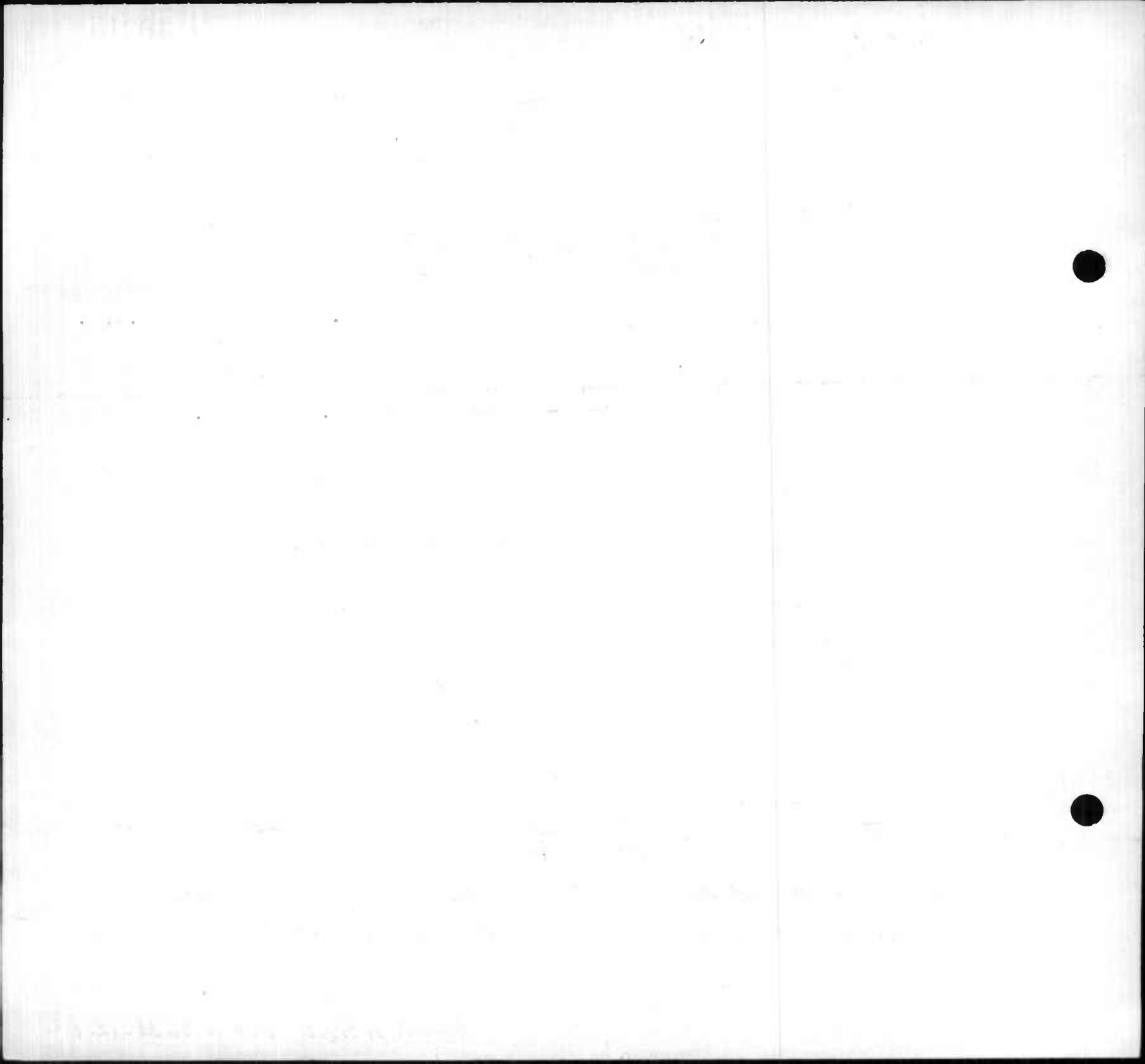
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |                                                                                                                                                                             | REG. NO. <u>71 10314</u>                                                 |                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| H-622 71 10314                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |                                                                                                                                                                             | CERTIFICATE OF DEATH                                                     |                                                                                                |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Julia C. Hargest</u>                                         |                                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><u>11/4/71</u> <u>4:30</u> <u>P.M.</u>      |                                                                                                |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>44 Union Memorial Hospital</u>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Md.</u> B. COUNTY <u>2706</u>                                          |                                                                          |                                                                                                |
| 5. SEX <u>F.</u> 6. RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        | 8. DATE OF BIRTH<br><u>1/21/1898</u>                                                                                                                                        |                                                                          | 9. AGE (In years last birthday) <u>73</u>                                                      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Hutzlers</u>                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                        | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                           |                                                                          | 11. BIRTHPLACE (State or foreign country)<br><u>N.J.</u>                                       |
| 13. FATHER'S NAME<br><u>Michael Griffin</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        | 14. MOTHER'S MAIDEN NAME<br><u>Mary Ellen Griffin</u>                                                                                                                       |                                                                          |                                                                                                |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>no</u>                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        | 16. SOCIAL SECURITY NO.                                                                                                                                                     |                                                                          | 17. INFORMANT<br><u>Mrs. Margaret Dreyer</u> ADDRESS <u>4832 Aberdeen Rd.</u>                  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>410.94 250.9</u><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><u>Diabetes Mellitus</u> |  |                                                                                                        | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Acute Myocardial Infarct</u><br>(B) <u>ASHD</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><u>2yrs</u><br><u>5yrs</u> |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                                                                                                                                                                             | 20A. AUTOPSY? (Yes or No)                                                |                                                                                                |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                                                                                                                                                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                                                |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> |                                                                                                                                                                             | 21F. HOW DID INJURY OCCUR?                                               |                                                                                                |
| 22. I certify that (1) (this hospital) attended the deceased from <u>Jan. 16</u> 19 <u>69</u> to <u>Nov. 4</u> 19 <u>71</u> and that (1) <u>lost</u> saw the deceased alive on <u>Nov. 4</u> 19 <u>71</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>Yes</u> (did) (did not) view the body after death.                                                                                                                                                            |  |                                                                                                        |                                                                                                                                                                             |                                                                          |                                                                                                |
| 23A. SIGNATURE<br><u>Stephen Toms, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |                                                                                                                                                                             | 23B. DATE SIGNED<br><u>11/5/71</u>                                       |                                                                                                |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Stephen Toms MD.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |                                                                                                                                                                             | 23D. ADDRESS<br><u>1712 Winford Road, Balto. Md.</u>                     |                                                                                                |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 24B. DATE<br><u>11/8/71</u>                                                                            |                                                                                                                                                                             | 24C. NAME of CEMETERY or CREMATORY<br><u>Moreland Mem. Pk.</u>           |                                                                                                |
| 24D. LOCATION<br><u>Balto. Md.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 24E. LOCATION (City, town, or county) (State)                                                          |                                                                                                                                                                             |                                                                          |                                                                                                |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 9 1971</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Fisher, M.D.</u>                                                |                                                                                                                                                                             | 25C. FUNERAL DIRECTOR<br><u>Leonard L. Buck Inc. Balto. Md.</u>          |                                                                                                |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                                                                                        |                                      |                                                                          |                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| M-624 71 10315                                                                                                                                                                                                                                                                                                                                                                                                      |                         | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                               |                                      | 71 10315                                                                 |                                                           |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>IDA K. MARSHALL</b>                                                                                                                                                          |                                      | 2. DATE AND HOUR OF DEATH<br><b>Nov 6, 1971 9 a. M.</b>                  |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>00</b><br><b>3149 Crittenton Place</b>                                                                                                                                                                                                                                                                     |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>1305</b>                                                                                      |                                      | C. CITY OR TOWN<br><b>Baltimore</b>                                      |                                                           |
| D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                       |                         | E. STREET AND NUMBER<br><b>3149 Crittenton Place</b>                                                                                                                                                                   |                                      |                                                                          |                                                           |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                             | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                            | 8. DATE OF BIRTH<br><b>6/20-1891</b> | 9. AGE (In years last birthday)<br><b>80</b>                             | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>                                                                                                                                                                                                                                                                                                    |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                                                                                                                                                       |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                  |                                                           |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                       |                         | 13. FATHER'S NAME<br><b>Jesse A. Daily</b>                                                                                                                                                                             |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Ida K. Barrett</b>                        |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]<br><b>No</b>                                                                                                                                                                                                                                                                                               |                         | 16. SOCIAL SECURITY NO.<br><b>212-05-7084-B</b>                                                                                                                                                                        |                                      | 17. INFORMANT<br><b>William J. Marshall. 1316 Asbury Rd.</b>             |                                                           |
| 18. <b>410.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>CORONARY THROMBOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>1 HR.</b>                                                                                                                 |                         | 19. <b>II</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>2 YRS</b> |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |                                                           |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                                                                                        |                                      |                                                                          |                                                           |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                       |                                      | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                                   |                                                           |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                                                                                        |                                      |                                                                          |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH finally medical examined <input type="checkbox"/>                                                                                                                                                                                                                                                                                                       |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                               |                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                           |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                           |                         | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/><br>Work At Work                                                                                                              |                                      | 21F. HOW DID INJURY OCCUR?                                               |                                                           |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1</b> <b>1952</b> to <b>Nov 6</b> <b>1971</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>Oct 25</b> <b>1971</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death. |                         |                                                                                                                                                                                                                        |                                      |                                                                          |                                                           |
| 23A. SIGNATURE<br><b>John M. Scott M.D.</b>                                                                                                                                                                                                                                                                                                                                                                         |                         | 23B. DATE SIGNED<br><b>Nov 6, 1971</b>                                                                                                                                                                                 |                                      | 23C. PHYSICIAN'S NAME (Type)<br><b>JOHN M. SCOTT</b>                     |                                                           |
| 23D. ADDRESS<br><b>600 W. NORTHERN PARKWAY BALTO 21210</b>                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                                                                                        |                                      |                                                                          |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                           |                         | 24B. DATE<br><b>11/9-71</b>                                                                                                                                                                                            |                                      | 24C. NAME of CEMETERY or CREMATORY<br><b>Lake View</b>                   |                                                           |
| 24D. LOCATION (City, town, or county) (State)<br><b>Carroll Co, Md. (Westminister)</b>                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                                                                                        |                                      |                                                                          |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 9 1971</b>                                                                                                                                                                                                                                                                                                                                                                |                         | 25B. NAME OF REGISTRAR<br><b>R. B. F. F. F. F.</b>                                                                                                                                                                     |                                      | 25C. FUNERAL DIRECTOR<br><b>Frank H. Seitz 814 W. 36 St 21211</b>        |                                                           |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                  |  |                                                                                          |  | REG. NO. 71 10316                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|
| G-653 71 10316                                                                                                                                                                                                                                                                                    |  |                                                                                          |  | CERTIFICATE OF DEATH                                                                  |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                         |  | 1. NAME OF DECEASED<br>(Type or Print)                                                   |  | 2. DATE AND HOUR OF DEATH                                                             |  |
|                                                                                                                                                                                                                                                                                                   |  | JULIA GARNETT                                                                            |  | 5 Nov. 71 6:40 A.M.                                                                   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                            |  |                                                                                          |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)                                                                                                                                                                                         |  |                                                                                          |  | A. STATE B. COUNTY                                                                    |  |
| 31 BALTIMORE CITY HOSPITAL<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224                                                                                                                                                                                                                    |  |                                                                                          |  | Maryland 1001                                                                         |  |
| 5. SEX                                                                                                                                                                                                                                                                                            |  | 6. RACE                                                                                  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  |
| Female                                                                                                                                                                                                                                                                                            |  | Negro                                                                                    |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                       |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |  | 8. DATE OF BIRTH                                                                      |  |
| PRESSER                                                                                                                                                                                                                                                                                           |  | TAILOR SHOP                                                                              |  | 11/8/25                                                                               |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                 |  | 14. MOTHER'S MAIDEN NAME                                                                 |  | 9. AGE (In years last birthday)                                                       |  |
| Morris E. Foote, Sr.                                                                                                                                                                                                                                                                              |  | Amanda Winder                                                                            |  | 45                                                                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                          |  | 16. SOCIAL SECURITY NO.                                                                  |  | 11. BIRTHPLACE (State or foreign country)                                             |  |
| No                                                                                                                                                                                                                                                                                                |  | 19-18-8204                                                                               |  | Maryland                                                                              |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                     |  | ADDRESS                                                                                  |  | 12. CITIZEN OF WHAT COUNTRY?                                                          |  |
| BCH-Records                                                                                                                                                                                                                                                                                       |  | 4940 Eastern Avenue<br>Baltimore, Maryland 21224                                         |  | U.S.A.                                                                                |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                |  |                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                    |  |                                                                                          |  |                                                                                       |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                      |  |                                                                                          |  |                                                                                       |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                 |  |                                                                                          |  |                                                                                       |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                         |  |                                                                                          |  |                                                                                       |  |
| II                                                                                                                                                                                                                                                                                                |  |                                                                                          |  |                                                                                       |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                  |  |                                                                                          |  |                                                                                       |  |
| ACUTE TUBERCULAR NECROSIS                                                                                                                                                                                                                                                                         |  |                                                                                          |  |                                                                                       |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                            |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  | 20A. AUTOPSY? (Yes or No)                                                             |  |
|                                                                                                                                                                                                                                                                                                   |  |                                                                                          |  | No                                                                                    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                             |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |
|                                                                                                                                                                                                                                                                                                   |  |                                                                                          |  |                                                                                       |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                     |  | 21E. INJURY OCCURRED                                                                     |  | 21F. HOW DID INJURY OCCUR?                                                            |  |
|                                                                                                                                                                                                                                                                                                   |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |                                                                                       |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10 Oct 1971 to 5 Nov 1971 that (I) last saw the deceased alive on 5 Nov 1971 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                          |  |                                                                                       |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                    |  |                                                                                          |  | 23B. DATE SIGNED                                                                      |  |
| Harvey M. Golomb M.D.                                                                                                                                                                                                                                                                             |  |                                                                                          |  | 5 Nov 71                                                                              |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                      |  |                                                                                          |  | 23D. ADDRESS                                                                          |  |
| Harvey M. Golomb M.D.                                                                                                                                                                                                                                                                             |  |                                                                                          |  | Baltimore City Hospitals<br>4940 EASTERN AVE.                                         |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                          |  | 24B. DATE                                                                                |  | 24C. NAME OF CEMETERY or CREMATORY                                                    |  |
| Burial                                                                                                                                                                                                                                                                                            |  | 11/8/71                                                                                  |  | Basil's                                                                               |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                   |  | 25B. NAME OF REGISTRAR                                                                   |  | 25C. FUNERAL DIRECTOR                                                                 |  |
| NOV 9 1971                                                                                                                                                                                                                                                                                        |  | Robert E. Barber, R.D.                                                                   |  | Wm. L. Chaturvedi                                                                     |  |
|                                                                                                                                                                                                                                                                                                   |  |                                                                                          |  | ADDRESS                                                                               |  |
|                                                                                                                                                                                                                                                                                                   |  |                                                                                          |  | 1701 7th Calhoun St.<br>Baltimore                                                     |  |

APPROXIMATE CITY MAP

APPROXIMATE CITY MAP

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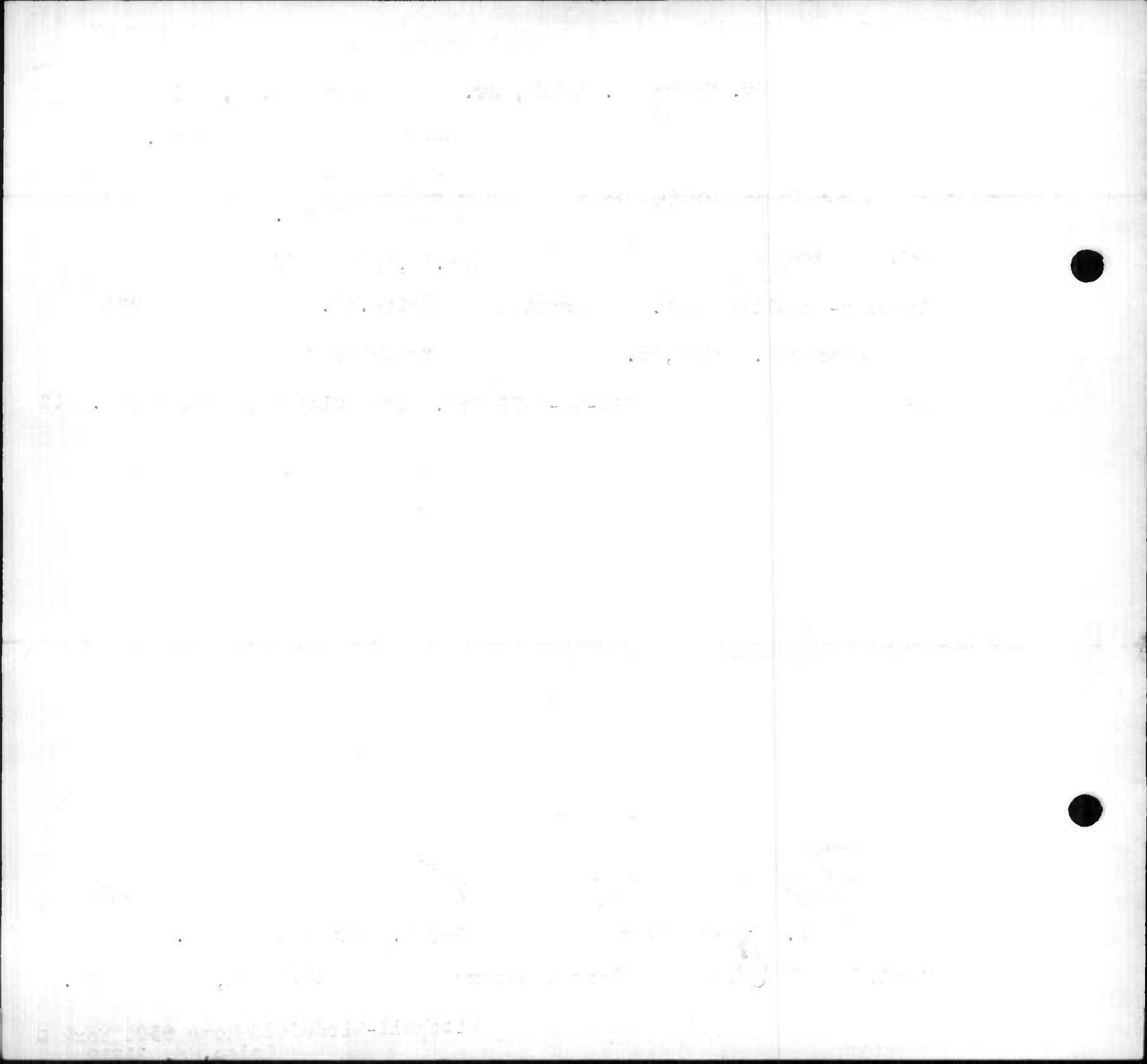
APPROXIMATE CITY MAP

APPROXIMATE CITY MAP

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                       |                                                                                               |                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| <p><b>5-530 71 10317</b></p> <p>BIRTH NO.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p><b>CERTIFICATE OF DEATH</b></p>                                                                                  |                                                                                                                                                                                                                                                                                                                                                       | <p>REG. NO. <b>71 10317</b></p>                                                               |                                                           |
| <p>1. NAME OF DECEASED<br/>(Type or Print)</p> <p style="text-align: center;"><b>Mr. George F. Smith, Jr.</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             | <p>2. DATE AND HOUR OF DEATH</p> <p style="text-align: center;"><b>November 5, 1971 11:30 P. M.</b></p>                                                                                                                                                                                                                                               |                                                                                               |                                                           |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p style="text-align: center;"><b>90 Long Green Nursing Home</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             | <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore Co.</b></p> <p>C. CITY OR TOWN <b>Rodgers Forge</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER <b>1 Regester Ave.</b></p> |                                                                                               |                                                           |
| 5. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 6. RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 16, 1890</b>                                                                                                                                                                                                                                                                                                              | 9. AGE (In years last birthday)<br><b>81</b>                                                  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Director-Supplies</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. of Education</b>                                                                                              |                                                                                                                                                                                                                                                                                                                                                       | 11. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b>                                |                                                           |
| 13. FATHER'S NAME<br><b>George F. Smith, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>Ora Neister</b>                                                                                                                                                                                                                                                                                                        |                                                                                               |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 16. SOCIAL SECURITY NO.<br><b>214-40-6972</b>                                                                                                               |                                                                                                                                                                                                                                                                                                                                                       | 17. INFORMANT ADDRESS<br><b>Mrs. Ruth Smith 1 Regester Ave. #12</b>                           |                                                           |
| <p>18. <b>437.91</b> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">(A) IMMEDIATE CAUSE <b>Coronary Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF: <b>2 yrs</b></p> <p style="text-align: center;">(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p style="text-align: center;">(C) DUE TO, OR AS A CONSEQUENCE OF:</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                       |                                                                                               |                                                           |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                                                                       | 20A. AUTOPSY? (Yes or No)                                                                     |                                                           |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                       |                                                                                               |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                                                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                           |
| 21D. TIME OF INJURY (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                                                                                                                                                                                       | 21F. HOW DID INJURY OCCUR?                                                                    |                                                           |
| <p>22. I certify that (I) (this hospital) attended the deceased, from <b>1934</b> to <b>Nov 5</b> 19<b>71</b> that (I) (we) last saw the deceased alive on <b>10/31/71</b> 19<b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                       |                                                                                               |                                                           |
| 23A. SIGNATURE<br><b>Francis W. Gluck</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                       | 23B. DATE SIGNED<br><b>11/5/71</b>                                                            |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. Francis Gluck</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                       | 23D. ADDRESS<br><b>100 W. University Pkwy.</b>                                                |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 24B. DATE<br><b>11/8/71</b>                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                       | 24C. NAME of CEMETERY or CREMATORY<br><b>Woodlawn Cemetery</b>                                |                                                           |
| 24D. LOCATION (City, town, or county)<br><b>Baltimore,</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 24E. (State)<br><b>Md.</b>                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                       |                                                                                               |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 9 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taber, M.D.</b>                                                                                                      |                                                                                                                                                                                                                                                                                                                                                       | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York R. Balto. Md. 21212</b> |                                                           |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                   |                     |                                                                                                                                                                                                              |  | 71 10318<br>REG. NO.                                                                          |                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--------------------------------------------------------|
| C-650 71 10318                                                                                                                                                                                                                                                                                                                                             |                     |                                                                                                                                                                                                              |  |                                                                                               |                                                        |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                  |                     | 1. NAME OF DECEASED<br>(Type or Print) <u>Paul Chearney</u>                                                                                                                                                  |  | 2. DATE AND HOUR OF DEATH<br><u>11/7/71</u> <u>1537</u> P. M.                                 |                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>CERTIFICATE AMENDED</b><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>South Baltimore General Hosp</u><br><u>43</u>                                                                                                      |                     | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>2302</u>                                                                   |  |                                                                                               |                                                        |
|                                                                                                                                                                                                                                                                                                                                                            |                     | C. CITY OR TOWN<br><u>Balto</u>                                                                                                                                                                              |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                        |
|                                                                                                                                                                                                                                                                                                                                                            |                     | E. STREET AND NUMBER<br><u>1403 Bataspco St</u>                                                                                                                                                              |  |                                                                                               |                                                        |
| 5. SEX<br><u>M</u>                                                                                                                                                                                                                                                                                                                                         | 6. RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                  |  | 8. DATE OF BIRTH<br><u>9/6/1912</u>                                                           | 9. AGE (In years last birthday)<br><u>59</u> <u>60</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Sheetmetal Worker A.K. Robins</u>                                                                                                                                                                                                                        |                     | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                            |  | 11. BIRTHPLACE (State or foreign country)<br><u>Balto. Md</u>                                 |                                                        |
| 13. FATHER'S NAME<br><u>Stephen Chearney</u>                                                                                                                                                                                                                                                                                                               |                     | 14. MOTHER'S MAIDEN NAME<br><u>Julia Chick</u>                                                                                                                                                               |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                    |                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>Unknown</u>                                                                                                                                                                                                                                 |                     | 16. SOCIAL SECURITY NO.<br><u>216-01-0716</u>                                                                                                                                                                |  | 17. INFORMANT<br><u>Hosp. chart</u>                                                           |                                                        |
| 18. <u>412.414250.9</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Aspiration + cardiac arrest</u><br>(B) <u>ASCRD</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <u>Peripheral vascular disease</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 min</u><br><u>5 yr</u><br><u>5 yr</u>    |                                                        |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                     |                     | <u>Diabetes mellitus</u>                                                                                                                                                                                     |  | <u>1 yr</u>                                                                                   |                                                        |
| 19A. DATE OF OPERATION<br><u>1/10/25</u>                                                                                                                                                                                                                                                                                                                   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Arteriosclerosis + stenosis illiac Ar.</u>                                                                                                            |  | 20A. AUTOPSY? (Yes or No)<br><u>NO</u>                                                        |                                                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><u>NO</u>                                                                                                                                                                                                                                                         |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><u>NO</u>                                                                                                        |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                        |
| 21D. TIME OF INJURY (APPROX.)<br>1 Month <input type="checkbox"/> 1 Day <input type="checkbox"/> 1 Year <input type="checkbox"/> 1 Hour <input type="checkbox"/>                                                                                                                                                                                           |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                    |  | 21F. HOW DID INJURY OCCUR?                                                                    |                                                        |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> 19 <u>71</u> to <u>11/7</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11/7</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.      |                     |                                                                                                                                                                                                              |  |                                                                                               |                                                        |
| 23A. SIGNATURE<br><u>Stanford G. Huber MD</u>                                                                                                                                                                                                                                                                                                              |                     | 23B. DATE SIGNED<br><u>11/7/71</u>                                                                                                                                                                           |  | 23C. PHYSICIAN'S NAME (Type)<br><u>Stanford G. Huber MD</u>                                   |                                                        |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                 |                     | 24B. DATE<br><u>11-11-71</u>                                                                                                                                                                                 |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery Balto.</u>                       |                                                        |
| 24D. LOCATION<br><u>Md.</u>                                                                                                                                                                                                                                                                                                                                |                     | 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 9 1971</u>                                                                                                                                                         |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Fisher, MD.</u>                                        |                                                        |
| 25C. FUNERAL DIRECTOR<br><u>McCully-130 E Fort Ave. Balto 21230</u>                                                                                                                                                                                                                                                                                        |                     | 25D. ADDRESS                                                                                                                                                                                                 |  |                                                                                               |                                                        |

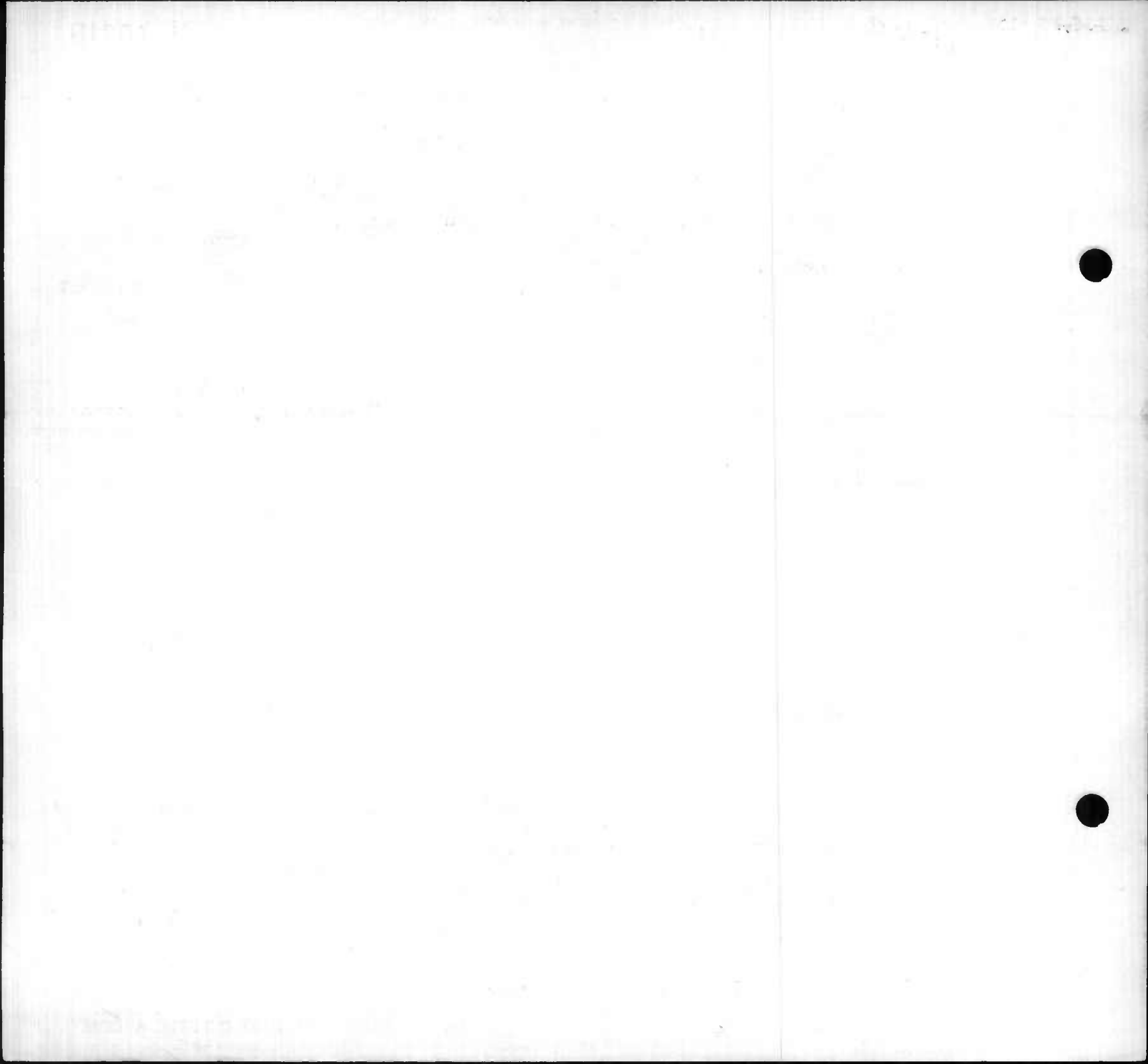
V.S. 153

12-1-71

M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                             |  |                                                                                                                                  |  |                                                                                                                                                      |  |
|---------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| N-132 71 10319                                                                                                                              |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                 |  | 71 10319                                                                                                                                             |  |
| BIRTH NO.                                                                                                                                   |  | CERTIFICATE OF DEATH                                                                                                             |  | REG. NO.                                                                                                                                             |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                      |  | 2. DATE AND HOUR OF DEATH                                                                                                        |  |                                                                                                                                                      |  |
| Magdalena Novetski                                                                                                                          |  | Nov 5 - 1971                                                                                                                     |  | 3:30A M.                                                                                                                                             |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                      |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                            |  |                                                                                                                                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                   |  | A. STATE                                                                                                                         |  | B. COUNTY                                                                                                                                            |  |
| Baltimore City Hospital                                                                                                                     |  | Maryland                                                                                                                         |  | 2636                                                                                                                                                 |  |
| 4940 Eastern Ave Baltio, Md 21224                                                                                                           |  | C. CITY OR TOWN                                                                                                                  |  | D. INSIDE CITY LIMITS?                                                                                                                               |  |
|                                                                                                                                             |  | Baltimore                                                                                                                        |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                  |  |
| 5. SEX                                                                                                                                      |  | 6. RACE                                                                                                                          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                                                |  |
| Female                                                                                                                                      |  | Caucasian                                                                                                                        |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                   |  |
| 8. DATE OF BIRTH                                                                                                                            |  | 9. AGE (in years last birthday)                                                                                                  |  | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                        |  |
| 11/18/09                                                                                                                                    |  | 62                                                                                                                               |  | house wife                                                                                                                                           |  |
| 11. BIRTHPLACE (State or foreign country)                                                                                                   |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                     |  |                                                                                                                                                      |  |
| Md.                                                                                                                                         |  | USA                                                                                                                              |  |                                                                                                                                                      |  |
| 13. FATHER'S NAME                                                                                                                           |  | 14. MOTHER'S MAIDEN NAME                                                                                                         |  |                                                                                                                                                      |  |
| George                                                                                                                                      |  | Lena                                                                                                                             |  |                                                                                                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                    |  | 16. SOCIAL SECURITY NO.                                                                                                          |  | 17. INFORMANT ADDRESS                                                                                                                                |  |
|                                                                                                                                             |  |                                                                                                                                  |  | BCH RECORDS- 4940 Eastern Avenue<br>Baltimore, Maryland 21224                                                                                        |  |
| 18. CAUSE OF DEATH                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                     |  |                                                                                                                                                      |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                              |  | (A) IMMEDIATE CAUSE                                                                                                              |  | 3 years                                                                                                                                              |  |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) |  | DUE TO, OR AS A CONSEQUENCE OF:                                                                                                  |  | Metastatic Carc<br>Cervix                                                                                                                            |  |
| ANTECEDENT CAUSES                                                                                                                           |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                              |  |                                                                                                                                                      |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                   |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                              |  |                                                                                                                                                      |  |
| II                                                                                                                                          |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  | Anemia - Obstructive Jaundice                                                                                                                        |  |
| 19A. DATE OF OPERATION                                                                                                                      |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  | 20A. AUTOPSY? (Yes or No)                                                                                                                            |  |
| 2                                                                                                                                           |  |                                                                                                                                  |  | YES                                                                                                                                                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                       |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)                                        |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                             |  |
|                                                                                                                                             |  |                                                                                                                                  |  |                                                                                                                                                      |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                               |  | 21E. INJURY OCCURRED                                                                                                             |  | 21F. HOW DID INJURY OCCUR?                                                                                                                           |  |
| (Month) (Day) (Year) (Hour)                                                                                                                 |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                |  |                                                                                                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from                                                                           |  | 11/4                                                                                                                             |  | 19 71 to 11/5 19 71                                                                                                                                  |  |
| that (I) (we) last saw the deceased alive on                                                                                                |  | 5/11 - 2 am                                                                                                                      |  | 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death. |  |
| 23A. SIGNATURE                                                                                                                              |  | 23B. DATE SIGNED                                                                                                                 |  |                                                                                                                                                      |  |
| Michele Codini M.D.                                                                                                                         |  | 11/5/71                                                                                                                          |  |                                                                                                                                                      |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                |  | 23D. ADDRESS                                                                                                                     |  |                                                                                                                                                      |  |
| Michele Codini                                                                                                                              |  | 4940 Eastern Avenue Balto, Md 21224                                                                                              |  |                                                                                                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                    |  | 24B. DATE                                                                                                                        |  | 24C. NAME of CEMETERY or CREMATORY                                                                                                                   |  |
| Burial                                                                                                                                      |  | 11-8-71                                                                                                                          |  | Parkwood Cemetery                                                                                                                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                             |  | 25B. NAME OF REGISTRAR                                                                                                           |  | 25C. FUNERAL DIRECTOR ADDRESS                                                                                                                        |  |
| NOV 9 1971                                                                                                                                  |  | Robert E. Saben, M.D.                                                                                                            |  | WALTER DABROWSKI 1005 DUNDALK AVENUE                                                                                                                 |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |                                                                                                                                    |                                                                          |                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| BIRTH NO. <b>Q-240</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                          |                                                                                                                                    | REG. NO. <b>71 10320</b>                                                 |                                                                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Quigley, Irene E.</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           | 2. DATE AND HOUR OF DEATH<br><b>11/6/71</b> <b>8:35</b> M.                                                                         |                                                                          |                                                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>North Charles General Hospital</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>2402</b> |                                                                          |                                                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>North Charles General Hospital</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                           | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                |                                                                          | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 5. SEX <b>Female</b> 6. RACE <b>CAUCASIAN</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                           |  |                                                                                                           | 8. DATE OF BIRTH<br><b>5-6-06</b>                                                                                                  |                                                                          | 9. AGE (In years last birthday) <b>65 YRS.</b>                                                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                                                                                                                                  |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                         |                                                                                                                                    | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>             |                                                                                               |
| 13. FATHER'S NAME<br><b>John L. Coarts</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                           | 14. MOTHER'S MAIDEN NAME<br><b>Janie Jordan</b>                                                                                    |                                                                          |                                                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                            |  | 16. SOCIAL SECURITY NO.<br><b>217-09-0858</b>                                                             |                                                                                                                                    | 17. INFORMANT ADDRESS<br><b>North Charles General CHART</b>              |                                                                                               |
| 18. <b>568 X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Cardiac arrest</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Poss pulmonary embolism</b><br><b>Abdominal adhesion Ectopic pregnancy</b> |  |                                                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                       |                                                                          |                                                                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                           |  |                                                                                                           |                                                                                                                                    |                                                                          |                                                                                               |
| 19A. DATE OF OPERATION<br><b>11-2-71</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Satisfactory</b>                                   |                                                                                                                                    | 20A. AUTOPSY? (Yes or No)                                                |                                                                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                            |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                   |                                                                                                                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                                               |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><b>11-6-71</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                                                                                                                    | 21F. HOW DID INJURY OCCUR?                                               |                                                                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-19-71</b> to <b>11-6-71</b> that (I) (we) last saw the deceased alive on <b>11-6-71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                         |  |                                                                                                           |                                                                                                                                    |                                                                          |                                                                                               |
| 23A. SIGNATURE<br><b>Lucas E. Vidnyaphum</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                           | 23B. DATE SIGNED<br><b>11-6-71</b>                                                                                                 |                                                                          |                                                                                               |
| 23C. PHYSICIAN'S NAME (Type)<br><b>LUCAS E. VIDNYAPHUM M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           | 23D. ADDRESS<br><b>North Charles General Hospital</b>                                                                              |                                                                          |                                                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  | 24B. DATE<br><b>11-9-71</b>                                                                               |                                                                                                                                    | 24C. NAME OF CEMETERY or CREMATORY<br><b>Gardens of Faith Cemetery</b>   |                                                                                               |
| 24D. LOCATION<br><b>Baltimore County, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 9 1971</b>                                                      |                                                                                                                                    |                                                                          |                                                                                               |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Tabor, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  | 25C. FUNERAL DIRECTOR<br><b>McGulley Funeral Home Balto., Md. 21230</b>                                   |                                                                                                                                    |                                                                          |                                                                                               |

17/11/71 - 11/2/71 - Operation

for Adhesions  
+ Repair of ventral Hernia - mid

With Dr. R. C. for Hsp.

| C-630                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 71 10321                                             |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                    |  | X                                                                          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                      |  | REG. NO. 71 10321                                                                                                                                                   |  |                                                                            |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                      |  |                                                                                                                                                                     |  |                                                                            |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Marlyn C. Cratty</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                      |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> Month <b>11</b> Day <b>5</b> Year <b>1971</b> Hour <b>1.25p</b> M. |  |                                                                            |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>40 St. Agnes Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                      |  | 3. DATE PRONOUNCED DEAD<br>Month <b>11</b> Day <b>5</b> Year <b>1971</b> Hour <b>1.25p</b> M.                                                                       |  |                                                                            |  |
| 6. SEX <b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                      |  | 7. RACE <b>Cauc.</b>                                                                                                                                                |  |                                                                            |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                      |  | 5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)<br>A. STATE <b>Md</b> B. COUNTY <b>Balto.</b> <b>5300</b>                     |  |                                                                            |  |
| 9. DATE OF BIRTH <b>7/30/41</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                      |  | 10. AGE (in years last birthday) <b>30</b>                                                                                                                          |  |                                                                            |  |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                      |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                                          |  |                                                                            |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                      |  | 14B. KIND OF BUSINESS OR INDUSTRY <b>Coun Home</b>                                                                                                                  |  |                                                                            |  |
| 15. MOTHER'S MAIDEN NAME <b>Mary Harner</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                      |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>                                                   |  |                                                                            |  |
| 17. SOCIAL SECURITY NO. <b>212-40-2491</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                      |  | 18. INFORMANT <b>Charles B. Cratty, Sr.</b> ADDRESS <b>3017 Georgia Ave</b>                                                                                         |  |                                                                            |  |
| 19. <b>450X</b> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                        |  |                                                                            |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                      |  | (A) IMMEDIATE CAUSE<br><b>Pulmonary Embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                 |  |                                                                            |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                      |  | (B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                        |  |                                                                            |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                      |  | (C) _____                                                                                                                                                           |  |                                                                            |  |
| 20A. DATE OF OPERATION <b>11/8/71</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                      |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                    |  |                                                                            |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                      |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                            |  |                                                                            |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                      |  | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                           |  |                                                                            |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                      |  | 22F. HOW DID INJURY OCCUR?                                                                                                                                          |  |                                                                            |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> DATE SIGNED <b>11 6 71</b><br>EXAMINER'S NAME (Type) |  |                                                      |  |                                                                                                                                                                     |  |                                                                            |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 24B. DATE <b>11/8/71</b>                             |  | 24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>                                                                                                       |  | 24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b> |  | 25C. FUNERAL DIRECTOR <b>Ambrase Inc. 1328 Sulphur Sp. Rd.</b>                                                                                                      |  | ADDRESS                                                                    |  |

1850

1850





05/18/73

FUNERAL DIRECTOR: IMPORTANT

WRIGHT, MARY

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| W-623 71 10322                                                                                                                                                                                                                                                                                           |  | BALTIMORE CITY HEALTH DEPARTMENT                                                         |  | 71 10322                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                |  | CERTIFICATE OF DEATH                                                                     |  | REG. NO.                                                                 |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                   |  | 2. DATE AND HOUR OF DEATH                                                                |  |                                                                          |  |
| MARY WRIGHT                                                                                                                                                                                                                                                                                              |  | 11 3 1971 12 PM                                                                          |  |                                                                          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)     |  |                                                                          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)                                                                                                                                                                                                |  | A. STATE B. COUNTY                                                                       |  |                                                                          |  |
| 33 Johns Hopkins Hospital Baltimore, MD                                                                                                                                                                                                                                                                  |  | MARYLAND                                                                                 |  | 1204                                                                     |  |
| 5. SEX                                                                                                                                                                                                                                                                                                   |  | 6. RACE                                                                                  |  |                                                                          |  |
| F                                                                                                                                                                                                                                                                                                        |  | N                                                                                        |  |                                                                          |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                                                                                                                                                                                                    |  | 8. DATE OF BIRTH                                                                         |  | 9. AGE (In years last birthday)                                          |  |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                       |  | 1-23-23                                                                                  |  | 48                                                                       |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                              |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |  | 11. BIRTHPLACE (State or foreign country)                                |  |
| Teacher                                                                                                                                                                                                                                                                                                  |  |                                                                                          |  | Warsaw VA.                                                               |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                        |  | 14. MOTHER'S MAIDEN NAME                                                                 |  | 12. CITIZEN OF WHAT COUNTRY?                                             |  |
| Unknown                                                                                                                                                                                                                                                                                                  |  | Canda                                                                                    |  |                                                                          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                 |  | 16. SOCIAL SECURITY NO.                                                                  |  | 17. INFORMANT ADDRESS                                                    |  |
|                                                                                                                                                                                                                                                                                                          |  | 217-20-3829                                                                              |  | Myra J. Wright 438 E 22nd St                                             |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                       |  | CAUSE OF DEATH                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                             |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |  | 5 minutes                                                                |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                        |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                      |  | 2 Months                                                                 |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                |  | (C) chronic renal disease, hypertension                                                  |  | 10 years                                                                 |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                      |  |                                                                                          |  |                                                                          |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  | 20A. AUTOPSY? (Yes or No)                                                |  |
| 2                                                                                                                                                                                                                                                                                                        |  |                                                                                          |  | Yes                                                                      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                    |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
|                                                                                                                                                                                                                                                                                                          |  |                                                                                          |  |                                                                          |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                            |  | 21E. INJURY OCCURRED                                                                     |  | 21F. HOW DID INJURY OCCUR?                                               |  |
|                                                                                                                                                                                                                                                                                                          |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |                                                                          |  |
| 22. I certify that (I) (this hospital) attended the deceased from 11/1/1971 to 11/3/1971 that (I) (we) last saw the deceased alive on 11/3/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                          |  |                                                                          |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                           |  | 23B. DATE SIGNED                                                                         |  |                                                                          |  |
| Keith L. Klein MD                                                                                                                                                                                                                                                                                        |  | 11/3/71                                                                                  |  |                                                                          |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                             |  | 23D. ADDRESS                                                                             |  |                                                                          |  |
| KEITH L. KLEIN                                                                                                                                                                                                                                                                                           |  | Johns Hopkins Hospital                                                                   |  |                                                                          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                 |  | 24B. DATE                                                                                |  | 24C. NAME OF CEMETERY or CREMATORY                                       |  |
| Burial                                                                                                                                                                                                                                                                                                   |  | 11-6-71                                                                                  |  | Arboretus                                                                |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                          |  | 25B. NAME OF REGISTRAR                                                                   |  | 25C. FUNERAL DIRECTOR ADDRESS                                            |  |
| NOV 9 1971                                                                                                                                                                                                                                                                                               |  | Robert E. Tabor, R.D.                                                                    |  | Carl Helmore 1827 W North Ave                                            |  |

Transfer  
Lithograph

Warren - VA  
Carter

2170-322 Myra / 11/18/1912

Barney 11-2-11 (11/2/11)

Belle 11-2-11

Carl 11-2-11 (11/2/11)

J-525-71 10323

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10323

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                    |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) Catherine Johnson                                                                                                                                                                                                                                                                                                                                                      |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 30 Year 71 Hour 3:15 p. M.                           |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>48 Maryland General Hospital                                                                                                                                                                                                                                                                                |  | 3. DATE PRONOUNCED DEAD Month 10 Day 30 Year 71 Hour 3:15 p. M.                                                                                                    |  |
| 6. SEX female                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7. RACE Negro                                                                                                                                                      |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                 |  | C. CITY OR TOWN Balto.                                                                                                                                             |  |
| 9. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                              |  | 10. AGE (In years lost birthday) 51                                                                                                                                |  |
| 11. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                     |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                       |  |
| 13. FATHER'S NAME GILBERT REED                                                                                                                                                                                                                                                                                                                                                                                |  | 14. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)<br>A. STATE Md. B. COUNTY 1506                                              |  |
| 15. MOTHER'S MAIDEN NAME IYA YOUNG                                                                                                                                                                                                                                                                                                                                                                            |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                            |  |
| 17. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                       |  | 18. INFORMANT CORLEE JOHNSON - 2846 W. NORTH AVE.                                                                                                                  |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>571.91                                                                                                                                                                                                    |  | CAUSE OF DEATH<br>Massive gastroesophageal hemorrhage                                                                                                              |  |
| 20. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                            |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                             |  |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                          |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                |  |
| 22. Cirrhosis of liver                                                                                                                                                                                                                                                                                                                                                                                        |  | (C)                                                                                                                                                                |  |
| 20A. DATE OF OPERATION 2                                                                                                                                                                                                                                                                                                                                                                                      |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                          |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                           |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                      |  | 22D. TIME OF INJURY (APPROX.)                                                                                                                                      |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                        |  | 22F. HOW DID INJURY OCCUR?                                                                                                                                         |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                                                    |  |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.                                                                                                                                                                                                                                                                                                                                                  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL                                                                                                                                                                                                                                                                                                                                                               |  | 24B. DATE 11/3/71                                                                                                                                                  |  |
| 24C. NAME OF CEMETERY or CREMATORY ARBUTUS MEMORIAL PK.                                                                                                                                                                                                                                                                                                                                                       |  | 24D. LOCATION (City, town, or county) (State) ARBUTUS, MD.                                                                                                         |  |
| 25A. DATE REC'D BY HEALTH DEPT. NOV 9 1971                                                                                                                                                                                                                                                                                                                                                                    |  | 25B. NAME OF REGISTRAR Robert E. Farber, M.D.                                                                                                                      |  |
| 25C. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                         |  | 25D. ADDRESS Earl Gilmore - 1827 W. North Ave.                                                                                                                     |  |

052075

052075

71 10324

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10324

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Donald Murray

2. DATE  
OF  
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

46 Lutheran Hosp

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

MD

1608

6. SEX

M

7. RACE

neg.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Balto

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

June 22, 1918

10. AGE (in years  
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

806 Lyndhurst Ave St

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

ANDREW MURRAY

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

PORTER

14B. KIND OF BUSINESS OR INDUSTRY

Tavern

15. MOTHER'S MAIDEN NAME

HELENIA CROSS

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes WWII 1941-1945

17. SOCIAL  
SECURITY NO.

216-05-9439

18. INFORMANT

Gladys Davis 806 Lyndhurst St

ADDRESS

19. E 965X 1

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Gunshot wound

1) chest &amp; back

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

606 Blk Poplar Grove St

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

11 4 717P

22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

shot during argument

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner H. Spitz

M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11. 7. 71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11/11/71

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn

24D. LOCATION (City, town, or county)

Balto MD

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 9 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Marshall P. Haynes 638 N. Charles St

ADDRESS

1881

FARMER'S

FARMER'S

To the Hon. Secy of the  
 U. S. Dept. of the Interior  
 Washington, D. C.  
 Sir:

I have the honor to acknowledge  
 the receipt of your letter of the  
 10th inst. in relation to the  
 land in question.

The same has been forwarded  
 to the proper authorities for  
 their consideration.

Very respectfully,  
 Yours, etc.,  
 J. M. Smith

J. M. Smith  
 U. S. Dept. of the Interior  
 Washington, D. C.

J. M. Smith  
 U. S. Dept. of the Interior  
 Washington, D. C.



| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                        |  | 2. DATE OF DEATH                                                                                                  |  | 3. DATE PRONOUNCED DEAD                                                                                                                                            |  | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                           |  | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)      |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|
| Norman Green                                                                                                                                                                                                                                                                                                                                                                                                  |  | Known <input checked="" type="checkbox"/> Month 11 Day 5 Year 71 Hour 7:10 a.m.                                   |  | Month 11 Day 5 Year 71 Hour 7:10 a.m.                                                                                                                              |  | Pier 3                                                                                                           |  | A. STATE Md. B. COUNTY 2006                                                                |  |
| 6. SEX male                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7. RACE Negro                                                                                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           |  | C. CITY OR TOWN Balto.                                                                                           |  | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 9. DATE OF BIRTH Doc 26-1920                                                                                                                                                                                                                                                                                                                                                                                  |  | 10. AGE (In years last birthday) 30                                                                               |  | 11. BIRTHPLACE (State or foreign country) Phila PA                                                                                                                 |  | 12. CITIZEN OF WHAT COUNTRY? USA                                                                                 |  | 13. FATHER'S NAME William Green                                                            |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter                                                                                                                                                                                                                                                                                                             |  | 14B. KIND OF BUSINESS OR INDUSTRY Restaurant                                                                      |  | 15. MOTHER'S MAIDEN NAME Ella Tucker                                                                                                                               |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII |  | 17. SOCIAL SECURITY NO 213139911                                                           |  |
| 18. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                 |  | ADDRESS                                                                                                           |  | 19. CAUSE OF DEATH                                                                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                     |  |                                                                                            |  |
| E 984X I                                                                                                                                                                                                                                                                                                                                                                                                      |  | Drowning                                                                                                          |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                |  |                                                                                                                  |  |                                                                                            |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                                                                |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                               |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                |  |                                                                                                                  |  |                                                                                            |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                   |  |                                                                                                                                                                    |  |                                                                                                                  |  |                                                                                            |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                     |  |                                                                                                                   |  |                                                                                                                                                                    |  |                                                                                                                  |  |                                                                                            |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                              |  |                                                                                                                   |  |                                                                                                                                                                    |  |                                                                                                                  |  |                                                                                            |  |
| 20A. DATE OF OPERATION 2                                                                                                                                                                                                                                                                                                                                                                                      |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                  |  | 21. AUTOPSY? (Yes or No) yes                                                                                                                                       |  |                                                                                                                  |  |                                                                                            |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                               |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unk.                     |  | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Unk.                                                                                      |  |                                                                                                                  |  |                                                                                            |  |
| 22D. TIME OF INJURY (APPROX.) unk.                                                                                                                                                                                                                                                                                                                                                                            |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | 22F. HOW DID INJURY OCCUR? Subject found in water at Pier 3.                                                                                                       |  |                                                                                                                  |  |                                                                                            |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |  | ACTUAL SIGNATURE Peter Lipkovic, M.D.                                                                             |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  | DATE SIGNED 11/5/71                                                                                              |  |                                                                                            |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Buried                                                                                                                                                                                                                                                                                                                                                               |  | 24B. DATE 11/9/71                                                                                                 |  | 24C. NAME OF CEMETERY or CREMATORY Mt Calvary                                                                                                                      |  | 24D. LOCATION (City, town, or county) (State) Baltimore 21225                                                    |  |                                                                                            |  |
| 25A. DATE REC'D BY HEALTH DEPT NOV 9 1971                                                                                                                                                                                                                                                                                                                                                                     |  | 25B. NAME OF REGISTRAR Robert E. Baker                                                                            |  | 25C. FUNERAL DIRECTOR                                                                                                                                              |  | ADDRESS                                                                                                          |  |                                                                                            |  |





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T-200

| 71 10326                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 71 10326                                                                                                   |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | REG. NO.                                                                                                   |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                            |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  | ALICE HOOKER (TUCK)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br>11 8 1971                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | Hour<br>6:05 a.m.                                                                                          |  |
| 00 2601 Cecil Ave.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md.                                                                                                                                                                                                                                                                                                                                                                                                                            |  | B. COUNTY 907                                                                                              |  |
| 6. SEX<br>female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 7. RACE<br>negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                      |  | C. CITY OR TOWN<br>Balto.                                                                                  |  |
| 9. DATE OF BIRTH<br>7/15-1900                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 10. AGE (In years last birthday)<br>71                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |  |
| 11. BIRTHPLACE (State or foreign country)<br>N.C.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | E. STREET AND NUMBER<br>2601 Cecil Ave.                                                                    |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Factory Worker                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 14B. KIND OF BUSINESS OR INDUSTRY<br>Tobacco                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME                                                                                   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 17. SOCIAL SECURITY NO.<br>244-42-5031                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 18. INFORMANT<br>Foster Tuck                                                                               |  |
| 19. 412-41                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic cardiovascular disease<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                               |  |
| 20A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 21. AUTOPSY? (Yes or No)<br>no                                                                             |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                   |  |
| 22D. TIME (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 22F. HOW DID INJURY OCCUR?                                                                                 |  |
| 23.<br>I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE: Werner U. Spitz, M.D.<br>EXAMINER'S NAME (Type)<br>DATE SIGNED: 11-8-71 |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                            |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | 24B. DATE<br>11/11/71                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 24C. NAME OF CEMETERY or CREMATORY<br>Mt. Calvary Cem.                                                     |  |
| 24D. LOCATION (City, town, or county) (State)<br>A.G. County, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 9 1971                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 25B. NAME OF REGISTRAR<br>Robert E. ...                                                                    |  |
| 25C. FUNERAL DIRECTOR<br>Joseph H. ...                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  | 25D. ADDRESS<br>1304 N. Central Ave.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                            |  |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-520 71 10327                                                                                                                                                                                                                                                                                                                                |  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                           |  | REG. NO. 71 10327                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                     |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Banks John</u>                                                                           |  | 2. DATE AND HOUR OF DEATH<br><u>11-4-71, 2:40 A.M.</u>                                                                       |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                        |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>MD.</u> B. COUNTY <u>1511</u> |  |                                                                                                                              |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>46 2801 Rayner Ave. Balt., Md. 21216</u><br><u>Lutheran Hospital.</u>                                                                                                                                                                                                                              |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                               |  | C. CITY OR TOWN <u>BALTIMORE.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX <u>M</u> 6. RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                |  | 8. DATE OF BIRTH <u>01-12-78</u> 9. AGE (in years last birthday) <u>93</u>                                                         |  | 10. If Under 1 Yr. Months: Days: Hours: Min.                                                                                 |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                   |  | 10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>                                                                                   |  | 11. BIRTHPLACE (State or foreign country) <u>Pa.</u>                                                                         |  |
| 13. FATHER'S NAME <u>Major Banks</u>                                                                                                                                                                                                                                                                                                          |  | 14. MOTHER'S MAIDEN NAME <u>Lucy</u>                                                                                               |  | 12. CITIZEN OF WHAT COUNTRY                                                                                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                      |  | 16. SOCIAL SECURITY NO.                                                                                                            |  | 17. INFORMANT <u>MRS. Vesta Copeland</u> ADDRESS <u>3814 Cedarvale Rd.</u>                                                   |  |
| 18. <u>151-91</u> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                              |  | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                 |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                  |  | (A) IMMEDIATE CAUSE <u>Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF:                                                           |  | <u>4 months.</u>                                                                                                             |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                             |  | (B) <u>Ca. Stomach</u> DUE TO, OR AS A CONSEQUENCE OF:                                                                             |  | <u>6 months</u>                                                                                                              |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                     |  | (C) _____                                                                                                                          |  |                                                                                                                              |  |
| II                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  |                                                                                                                              |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                              |  |                                                                                                                                    |  |                                                                                                                              |  |
| 19A. DATE OF OPERATION <u>11-29-71</u>                                                                                                                                                                                                                                                                                                        |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>polyp of stomach</u>                                                           |  | 20A. AUTOPSY? (Yes or No) <u>NO</u>                                                                                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                           |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                     |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                     |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                             |  | 21F. HOW DID INJURY OCCUR?                                                                                                   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-15-71</u> 19 <u>71</u> to <u>11-4-1971</u> and that (I) (we) lost saw the deceased alive on <u>11-3-1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                    |  |                                                                                                                              |  |
| 23A. SIGNATURE <u>Magbook A. Wawrich</u>                                                                                                                                                                                                                                                                                                      |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>               |  | 23B. DATE SIGNED <u>11-4-71</u>                                                                                              |  |
| 23C. PHYSICIAN'S NAME (Type) <u>Magbook A. Wawrich</u>                                                                                                                                                                                                                                                                                        |  | 23D. ADDRESS <u>Lutheran Hosp. of Md. Balt., Md. 21216</u>                                                                         |  |                                                                                                                              |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>B.</u>                                                                                                                                                                                                                                                                                            |  | 24B. DATE <u>11-6-71</u>                                                                                                           |  | 24C. NAME of CEMETERY or CREMATORY <u>MT. Auburn Cemetery</u>                                                                |  |
| 24D. LOCATION (City, town, or county) <u>Westport Maryland</u>                                                                                                                                                                                                                                                                                |  | 24E. (State) <u>21216</u>                                                                                                          |  |                                                                                                                              |  |
| 25A. DATE REC'D BY HEALTH DEPT. <u>NOV 9 1971</u>                                                                                                                                                                                                                                                                                             |  | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD.</u>                                                                                |  | 25C. FUNERAL DIRECTOR <u>Joseph L. Russ</u> ADDRESS <u>2222-24 W. North Ave. Baltimore</u>                                   |  |

3814 Cedar Dale Rd. 21209

Adm. Approx. 1 yr. ago.

P-660 71 10328

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 10328  
REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>WALTER PRYOR</b>                                                                                                                                                                                                                                                                                                                                                           |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.                                                                                           |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>38 University Hospital</b>                                                                                                                                                                                                                                                                                      |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>11 7 1971 6:25a</b> M.                                                                                                                          |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>1601</b>                                                                                                                                                                                                                                                                                   |  | 6. SEX <b>male</b> 7. RACE <b>negro</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                |  |
| 9. DATE OF BIRTH <b>Aug 27, 1911</b> 10. AGE (In years last birthday) <b>60</b> 11. BIRTHPLACE (State or foreign country) <b>Pamplin Va</b>                                                                                                                                                                                                                                                                          |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 13. FATHER'S NAME <b>Thomas H. Pryor</b>                                                                                                                  |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>househusband</b> 14B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>                                                                                                                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME <b>Fannie Miller</b>                                                                                                                                                        |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) <b>No</b>                                                                                                                                                                                                                                                                                                    |  | 17. SOCIAL SECURITY NO. <b>212-05-8325</b> 18. INFORMANT <b>Mrs Helen Pryor</b> ADDRESS <b>940 Bennett Pl</b>                                                                                        |  |
| 19. <b>45491</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Ruptured varix of legs with exsanguination</b>                                                                                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                         |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                       |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                               |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                     |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                  |  |
| II<br><b>Fatty metamorphosis, liver<br/>Pulmonary emphysema</b>                                                                                                                                                                                                                                                                                                                                                      |  | (C)                                                                                                                                                                                                  |  |
| 20A. DATE OF OPERATION <b>2</b> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                     |  | 21. AUTOPSY? (Yes or No) <b>yes</b>                                                                                                                                                                  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                 |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                             |  |
| 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                             |  | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)                                                                                                                                            |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                               |  | 22F. HOW DID INJURY OCCUR?                                                                                                                                                                           |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                                                                                      |  |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>                                                                                                                                                                                                                                                                                                                                                 |  | Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11-8-71</b> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                               |  | 24B. DATE <b>Aug 11, 1971</b> 24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Co</b>                                                                                                                 |  |
| 24D. LOCATION (City, town, or county) (State) <b>Westport Md</b>                                                                                                                                                                                                                                                                                                                                                     |  | 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1971</b> 25B. NAME OF REGISTRAR <b>Robert E. Bailey, M.D.</b>                                                                                               |  |
| 25C. FUNERAL DIRECTOR <b>Joseph H. Ruse</b>                                                                                                                                                                                                                                                                                                                                                                          |  | ADDRESS <b>2222 W North Ave</b>                                                                                                                                                                      |  |

8857

RECEIVED BY THE MEDICAL EXAMINER

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RECEIVED BY THE MEDICAL EXAMINER

U.S. DEPT. OF JUSTICE

U.S. DEPT. OF JUSTICE



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                   | CERTIFICATE OF DEATH                                                                                                                                                                                                           |                                                                                                           | REG. NO. <u>71 10329</u>                                                                      |                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| B-620 71 10329<br>BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                   | 1. NAME OF DECEASED<br>(Type or Print) <b>BRISCOE, VICTOR REED</b>                                                                                                                                                             |                                                                                                           | 2. DATE AND HOUR OF DEATH<br><b>11/4/71 9:45 A</b> M.                                         |                                                                     |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2710</b>                                                                                     |                                                                                                           |                                                                                               |                                                                     |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>23 Veterans Administration Hospital<br/>3900 Loch Raven Boulevard<br/>Baltimore, Maryland 21218</b>                                                                                                                                                                                  |                         |                                                                                                                                                             |                                   | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                                                                            |                                                                                                           | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                     |
| E. STREET AND NUMBER<br><b>539 Richmond Avenue</b>                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                   |                                                                                                                                                                                                                                |                                                                                                           |                                                                                               |                                                                     |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                | 6. RACE<br><b>Negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/1/12</b> | 9. AGE (In years last birthday)<br><b>59</b>                                                                                                                                                                                   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cook</b> |                                                                                               | 11. BIRTHPLACE (State or foreign country)<br><b>Ridge, Maryland</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cook</b>                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>VA Hospital</b>                                                                                                                                                                        |                                                                                                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                    |                                                                     |
| 13. FATHER'S NAME<br><b>Randolph Briscoe</b>                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             |                                   | 14. MOTHER'S MAIDEN NAME<br><b>Dora Reid</b>                                                                                                                                                                                   |                                                                                                           |                                                                                               |                                                                     |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes 12/19/44 - 4/22/46</b>                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                   | 16. SOCIAL SECURITY NO.<br><b>755-01-9058</b>                                                                                                                                                                                  |                                                                                                           | 17. INFORMANT<br><b>VA Hospital Records<br/>3900 Loch Raven Boulevard, Balto., Md 21218</b>   |                                                                     |
| 18. <b>431.0 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>4 days</b>                                                                                               |                         |                                                                                                                                                             |                                   | 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Hypertensive vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>4 days</b> |                                                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b>                                 |                                                                     |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                   |                                                                                                                                                                                                                                |                                                                                                           |                                                                                               |                                                                     |
| 19A. DATE OF OPERATION<br><b>1</b>                                                                                                                                                                                                                                                                                                                                                                   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                   | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>                                                                                                                                                                                        |                                                                                                           | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b>            |                                                                     |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                                              |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                   | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                                                                                    |                                                                                                           |                                                                                               |                                                                     |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                            |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                   | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                     |                                                                                                           |                                                                                               |                                                                     |
| 22. I certify that <b>NY</b> (this hospital) attended the deceased from <b>October 31st</b> 19 <b>71</b> to <b>November 4th</b> 19 <b>71</b> , that <b>NY</b> (we) last saw the deceased alive on <b>November 4th</b> 19 <b>71</b> and that <b>NY</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>NY</b> (We) (did) <b>not</b> view the body after death. |                         |                                                                                                                                                             |                                   |                                                                                                                                                                                                                                |                                                                                                           |                                                                                               |                                                                     |
| 23A. SIGNATURE<br><b>Kameel Farag, M.D.</b>                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                   | 23B. DATE SIGNED<br><b>11/5/71</b>                                                                                                                                                                                             |                                                                                                           |                                                                                               |                                                                     |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Kameel Farag, m.d.</b>                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                   | 23D. ADDRESS<br><b>3900 Loch Raven Boulevard<br/>Baltimore, Maryland 21218</b>                                                                                                                                                 |                                                                                                           |                                                                                               |                                                                     |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                            |                         | 24B. DATE<br><b>11-8-71</b>                                                                                                                                 |                                   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>CARVER MEM. PARK</b>                                                                                                                                                                  |                                                                                                           | 24D. LOCATION (City, town, or county) (State)<br><b>LAUREL Md. AVG</b>                        |                                                                     |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 9 1971</b>                                                                                                                                                                                                                                                                                                                                                 |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>                                                                                                     |                                   | 25C. FUNERAL DIRECTOR<br><b>ELROY O. Wilson</b>                                                                                                                                                                                |                                                                                                           | ADDRESS<br><b>1000 BRANTLEY</b>                                                               |                                                                     |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                                                                                                                                                                                                          | REG. NO. <u>71 10330</u>                                                         |                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| BIRTH NO. <u>1-250 71 10330</u>                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |                                                                                                                                                                                                                          | CERTIFICATE OF DEATH                                                             |                                                                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Wendell Jackson</u>                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><u>11-1-71</u> <u>8:27 P</u> M.                                                                                                                                                             |                                                                                  |                                                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br><u>37 Mercy Hospital</u>                                                                                                                                                            |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>301</u>                                                                                    |                                                                                  |                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                                                                                      |                                                                                  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             | E. STREET AND NUMBER<br><u>39 S. Dallas St. #21231</u>                                                                                                                                                                   |                                                                                  |                                                                                               |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                                                                              | 6. RACE<br><u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>4-13-97</u>                                                                                                                                                                                       | 9. AGE (In years last birthday)<br><u>74</u>                                     | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min.                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                        |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                                                                                                                                                                                                          | 11. BIRTHPLACE (State or foreign country)<br><u>Virginia</u>                     |                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |                                                                                                                                                                                                                          | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                       |                                                                                               |
| 13. FATHER'S NAME<br><u>David Jackson</u>                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><u>Mary Campbell</u>                                                                                                                                                                         |                                                                                  |                                                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                           |                         | 16. SOCIAL SECURITY NO.                                                                                                                                     | 17. INFORMANT<br><u>VIOLA MARK</u> ADDRESS<br><u>39 S. DALLAS CT.</u>                                                                                                                                                    |                                                                                  |                                                                                               |
| 18. <u>451.91</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.          |                         |                                                                                                                                                             | CAUSE OF DEATH<br><br>(A) IMMEDIATE CAUSE<br><u>Pulmonary Embolism</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Phlebitis</u><br>(C) _____ |                                                                                  |                                                                                               |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                   |                         |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                             |                                                                                  |                                                                                               |
| 19A. DATE OF OPERATION<br><u>1</u>                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                         |                                                                                  | 20A. AUTOPSY? (Yes or No)<br><u>Yes</u>                                                       |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                  |                                                                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examined)                                                                                                                                                                                                                                                                            |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)         |                                                                                               |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                          |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                                          | 21F. HOW DID INJURY OCCUR?                                                       |                                                                                               |
| 22. I certify that (X) (this hospital) attended the deceased from <u>10-20</u> <u>19</u> <u>71</u> to <u>11-1</u> <u>19</u> <u>71</u> that (X) (we) last saw the deceased alive on <u>11-1</u> <u>19</u> <u>71</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death. |                         |                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                  |                                                                                               |
| 23A. SIGNATURE<br><u>S. Malek, M.D.</u>                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             | 23B. DATE SIGNED<br><u>11-1-71</u>                                                                                                                                                                                       |                                                                                  |                                                                                               |
| 23C. PHYSICIAN'S NAME (Type)<br><u>S. Malek</u>                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             | 23D. ADDRESS<br><u>301 St. Paul Place</u>                                                                                                                                                                                |                                                                                  |                                                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                                          |                         | 24B. DATE<br><u>11-5-71</u>                                                                                                                                 |                                                                                                                                                                                                                          | 24C. NAME OF CEMETERY OR CREMATORY<br><u>MT CALVARY</u>                          |                                                                                               |
| 24D. LOCATION (City, town, or county) (State)<br><u>ARUNDEL Co. Md</u>                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                  |                                                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 9 1971</u>                                                                                                                                                                                                                                                                                                               |                         | 25B. NAME OF REGISTRAR<br><u>R. E. Taylor M.D.</u>                                                                                                          |                                                                                                                                                                                                                          | 25C. FUNERAL DIRECTOR<br><u>E. O. Wilson</u> ADDRESS<br><u>1000 BRANTLEY AVE</u> |                                                                                               |

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ARCADE CO. INC.

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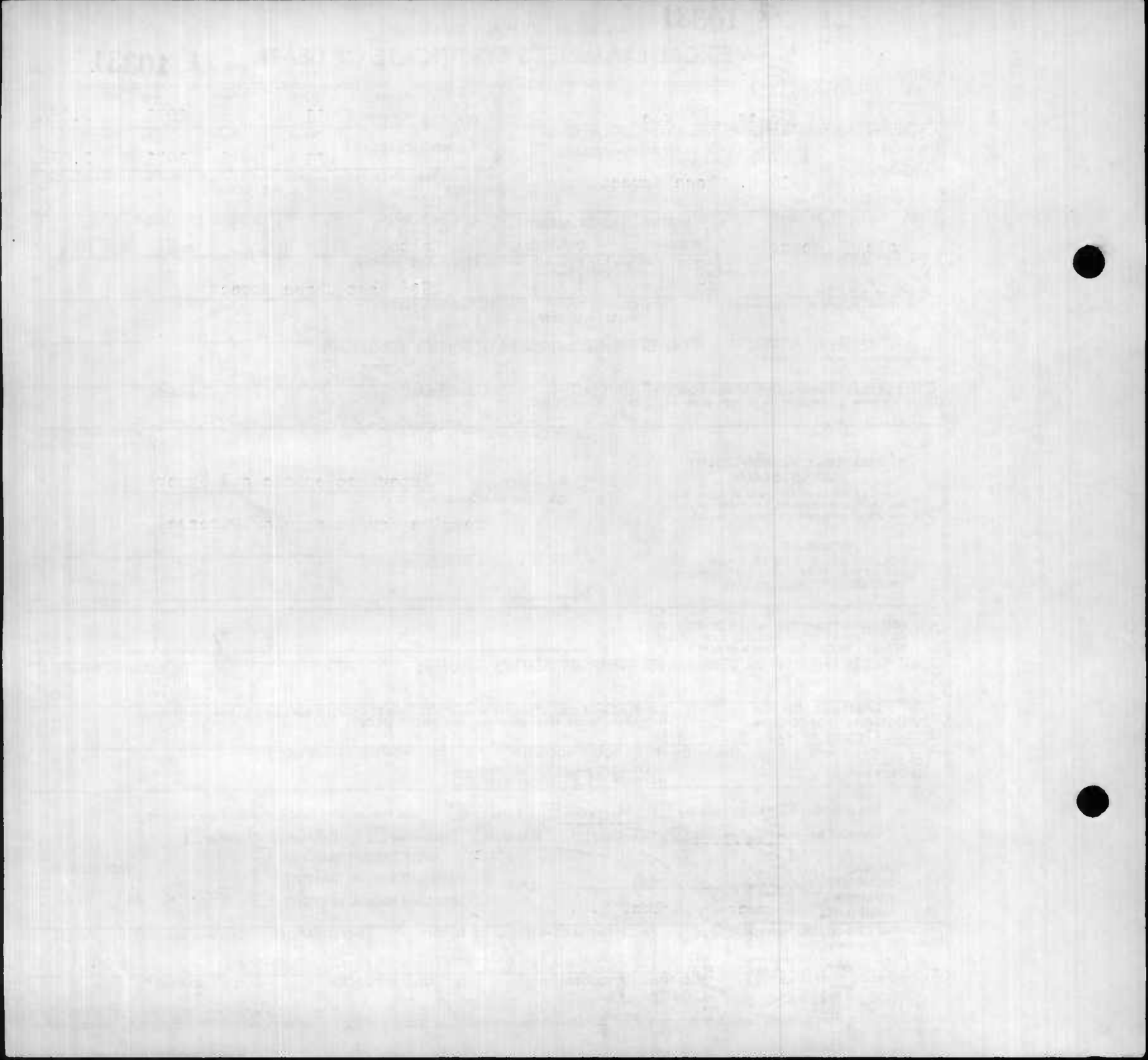
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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 10331

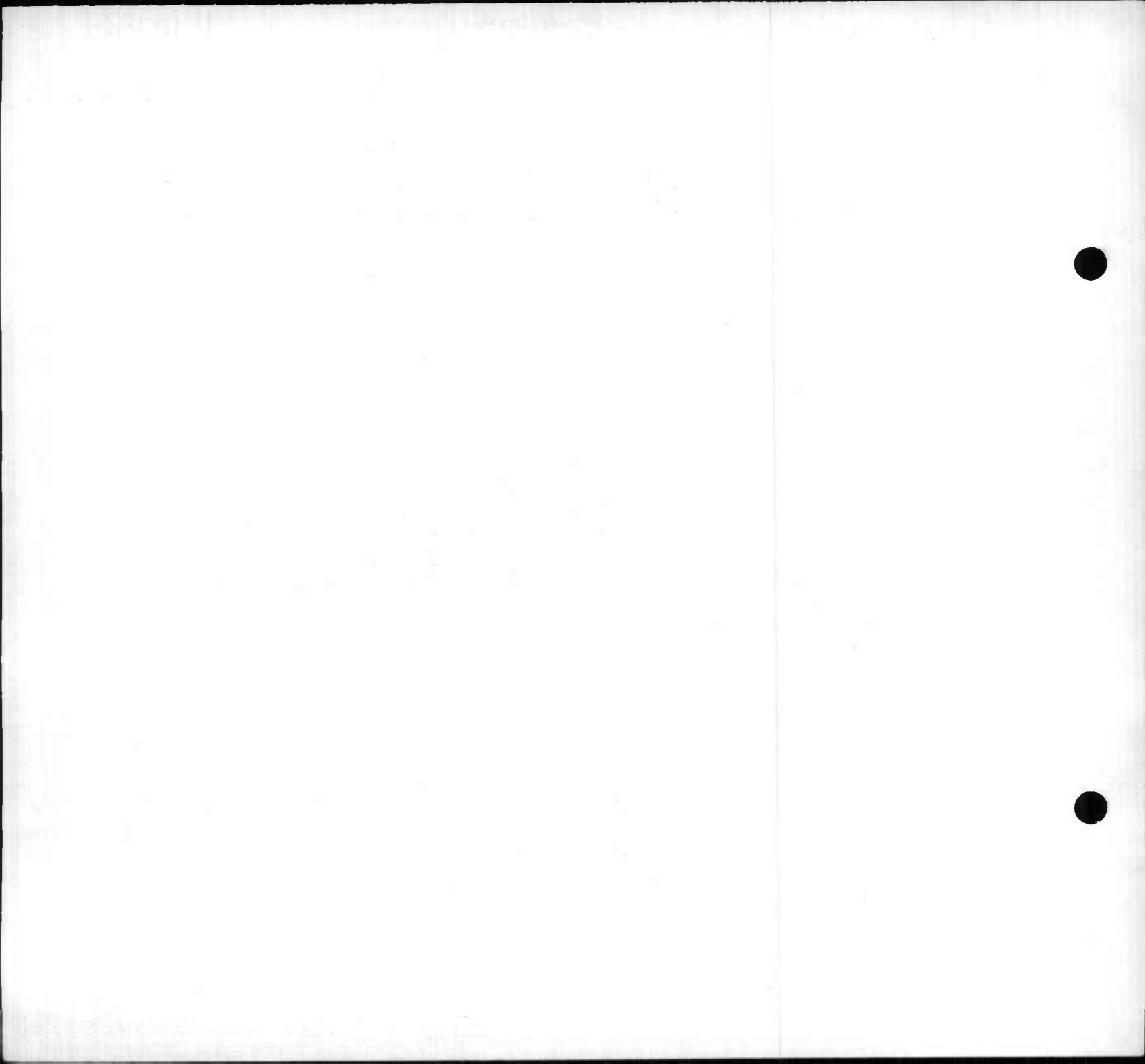
BIRTH NO.

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>James D. Horne                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input checked="" type="checkbox"/> 11 6 1971<br>Hour 3.05A.M. |  |                                                                                                                                                  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>2516 E. Chase Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br>11 6 1971<br>Hour 3.05A.M.                                                                       |  |                                                                                                                                                  |  |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                  |  | 7. RACE<br>Negro                                                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br>May 2 1904                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                  |  | 10. AGE (In years last birthday)<br>67                                                                                                        |  | 11. BIRTHPLACE (State or foreign country)<br>North Carolina                                                                                      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                  |  | 13. FATHER'S NAME<br>Dennis Horne                                                                                                             |  |                                                                                                                                                  |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                  |  | 15. MOTHER'S MAIDEN NAME<br>Mantha Monroe                                                                                                     |  |                                                                                                                                                  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                  |  | 17. SOCIAL SECURITY NO.<br>218-01-9251                                                                                                        |  | 18. INFORMANT<br>Queenie Horne                                                                                                                   |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic and Hypertensive cardiovascular Disease<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                          |  |                                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                  |  |                                                                                                                                                  |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |  |                                                                                                                                                  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                      |  |                                                                                                                                                  |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                  |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                     |  |                                                                                                                                                  |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                  |  | 22F. HOW DID INJURY OCCUR?                                                                                                                    |  |                                                                                                                                                  |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.<br>M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Nov. 6, 1971 |  |                                                  |  |                                                                                                                                               |  |                                                                                                                                                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 24B. DATE<br>11-11-71                            |  | 24C. NAME OF CEMETERY or CREMATORY<br>Crown Cent                                                                                              |  | 24D. LOCATION (City, town, or county) (State)<br>Lanham Md                                                                                       |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 9 1971                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, M.D. |  | 25C. FUNERAL DIRECTOR<br>E. Wilson                                                                                                            |  | ADDRESS<br>Brently H                                                                                                                             |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

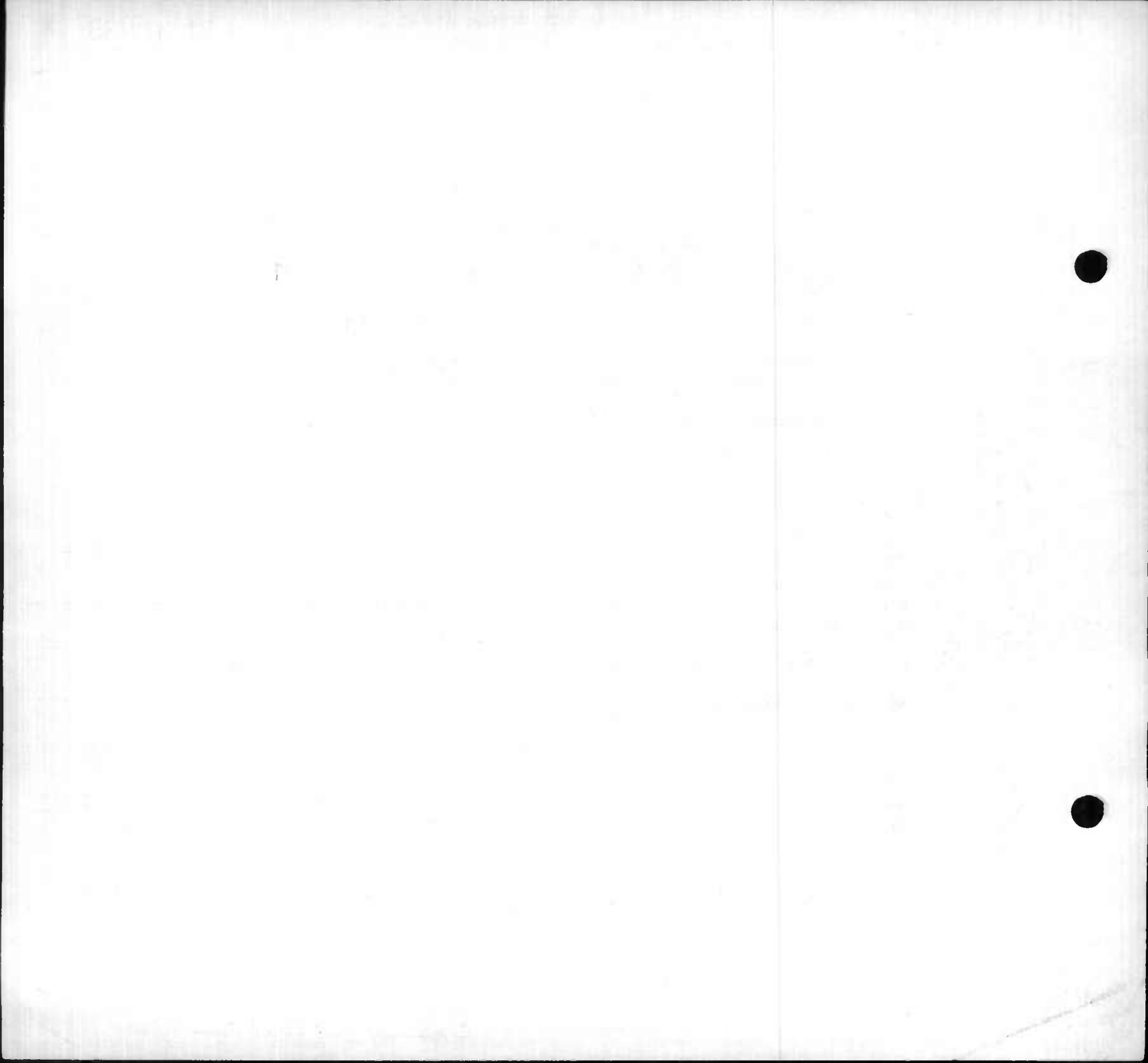
|                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                               |  |                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|
| C-636 71 10332                                                                                                                                                                                                                                                                                                                                                |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                              |  | 71 10332                                                                                      |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                     |  | CERTIFICATE OF DEATH                                                                                                                                                                                          |  | REG. NO.                                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>FRANCES CARTER</b>                                                                                                                                                                                                                                                                                                  |  | 2. DATE AND HOUR OF DEATH<br><b>Nov 7 - 1971 2:50 A.M.</b>                                                                                                                                                    |  |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                        |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1601</b>                                                                       |  |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>90 Mt Sinai Nursing Home</b><br><b>4613 Park Heights Ave</b><br><b>Baltimore Md 21205</b>                                                                                                                                                                                                                          |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                          |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                           |  |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                       |  | 6. RACE<br><b>C N</b>                                                                                                                                                                                         |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                   |  | 8. DATE OF BIRTH<br><b>7-9-77</b>                                                                                                                                                                             |  | 9. AGE (In years last birthday) <b>94</b>                                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                               |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                             |  | 11. BIRTHPLACE (State or foreign country)                                                     |  |
| 13. FATHER'S NAME<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>                                                                                                                                                                    |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                         |  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                       |  | 17. INFORMANT ADDRESS                                                                         |  |
| 18. <b>412.4 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.        |  | CAUSE OF DEATH<br><b>Pneumonia</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Cerebrovascular Disease</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Chronic Brain Syndrome</b><br>(C) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>                                 |  |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                               |  |                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                        |  |                                                                                                                                                                                                               |  |                                                                                               |  |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                            |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                              |  | 20A. AUTOPSY? (Yes or No)                                                                     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                      |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                     |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                     |  | 21F. HOW DID INJURY OCCUR?                                                                    |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Oct 27</b> 19 <b>71</b> to <b>Nov 7</b> 19 <b>71</b> and that (I) (we) lost saw the deceased alive on <b>Nov 6</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                                                                               |  |                                                                                               |  |
| 23A. SIGNATURE<br><b>Louis T. Lavy M.D.</b>                                                                                                                                                                                                                                                                                                                   |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>                                                                               |  | 23B. DATE SIGNED<br><b>Nov 7 - 1971</b>                                                       |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>LOUIS T. LAVY</b>                                                                                                                                                                                                                                                                                                          |  | 23D. ADDRESS<br><b>M.D. 3502 W. Rogers Ave Baltimore Md.</b>                                                                                                                                                  |  |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Buried</b>                                                                                                                                                                                                                                                                                                     |  | 24B. DATE<br><b>11-11-71</b>                                                                                                                                                                                  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Baltimore Natl Cml</b>                               |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b>                                                                                                                                                                                                                                                                                          |  | 25A. DATE RECD BY HEALTH DEPT.<br><b>NOV 9 1971</b>                                                                                                                                                           |  | 25B. NAME OF REGISTRAR<br><b>ECRAY O. WILSON</b>                                              |  |
| 25C. FUNERAL DIRECTOR<br><b>1000 BRANTLEY AVE</b>                                                                                                                                                                                                                                                                                                             |  | 25D. ADDRESS                                                                                                                                                                                                  |  |                                                                                               |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |                                                                                                                                     | REG. NO. <b>71 10333</b>                                                 |                                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| BIRTH NO. <b>2-536 71 10333</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |                                                                                                                                     | CERTIFICATE OF DEATH                                                     |                                                                                                                                                             |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Wanda Sanders</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                           | 2. DATE AND HOUR OF DEATH<br><b>Nov. 3 - 1971 10:11 PM</b>                                                                          |                                                                          |                                                                                                                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>90 Harbor View Conv. Center</b>                                                                                                                                                                                               |  |                                                                                                           | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b><br>B. COUNTY <b>361</b> |                                                                          |                                                                                                                                                             |
| 5. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           | 6. RACE <b>C</b>                                                                                                                    |                                                                          | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH <b>6-3-03</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                           | 9. AGE (In years last birthday) <b>67</b>                                                                                           |                                                                          | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                                                                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                           | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                   |                                                                          |                                                                                                                                                             |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                          |                                                                          |                                                                                                                                                             |
| 13. FATHER'S NAME<br><b>J.P. Hawkins</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                           | 14. MOTHER'S MAIDEN NAME<br><b>Mary -</b>                                                                                           |                                                                          |                                                                                                                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>unknown</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                           | 16. SOCIAL SECURITY NO.<br><b>231-03-3832</b>                                                                                       |                                                                          | 17. INFORMANT<br><b>Fredrick Chandler</b>                                                                                                                   |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Cardiac arrest</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>A.S.P. V. Disease</b> |  |                                                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Instant</b>                                                                      |                                                                          |                                                                                                                                                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Septic Bacteremia</b>                                                                                                                                                                                                                                          |  |                                                                                                           | ?                                                                                                                                   |                                                                          |                                                                                                                                                             |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                      |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |                                                                                                                                     | 20A. AUTOPSY (Yes or No)<br><b>No</b>                                    |                                                                                                                                                             |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |                                                                                                                                     |                                                                          |                                                                                                                                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                              |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                                                                                                                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                                                                                                             |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                                                                                                                     | 21F. HOW DID INJURY OCCUR?                                               |                                                                                                                                                             |
| 22. I certify that (I) (this hospital) attended the deceased from <b>3/22</b> 19 <b>69</b> to <b>11/31</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>10/3</b> 19 <b>71</b> and that in (my) (our) opinion, death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                     |  |                                                                                                           |                                                                                                                                     |                                                                          |                                                                                                                                                             |
| 23A. SIGNATURE<br><b>Joseph S. Blum MD</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           | 23B. DATE SIGNED<br><b>11/5/71</b>                                                                                                  |                                                                          | 23C. PHYSICIAN'S NAME (Type)<br><b>JOSEPH S. BLUM MD</b>                                                                                                    |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>11-8-71</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           | 24B. DATE                                                                                                                           |                                                                          | 24C. NAME of CEMETERY or CREMATORY<br><b>Not known</b>                                                                                                      |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 9 1971</b>                                                                                |                                                                          |                                                                                                                                                             |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                           | 25C. FUNERAL DIRECTOR<br><b>Henry O. Wilson</b>                                                                                     |                                                                          |                                                                                                                                                             |
| 25D. ADDRESS<br><b>10000 Bunting</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |                                                                                                                                     |                                                                          |                                                                                                                                                             |



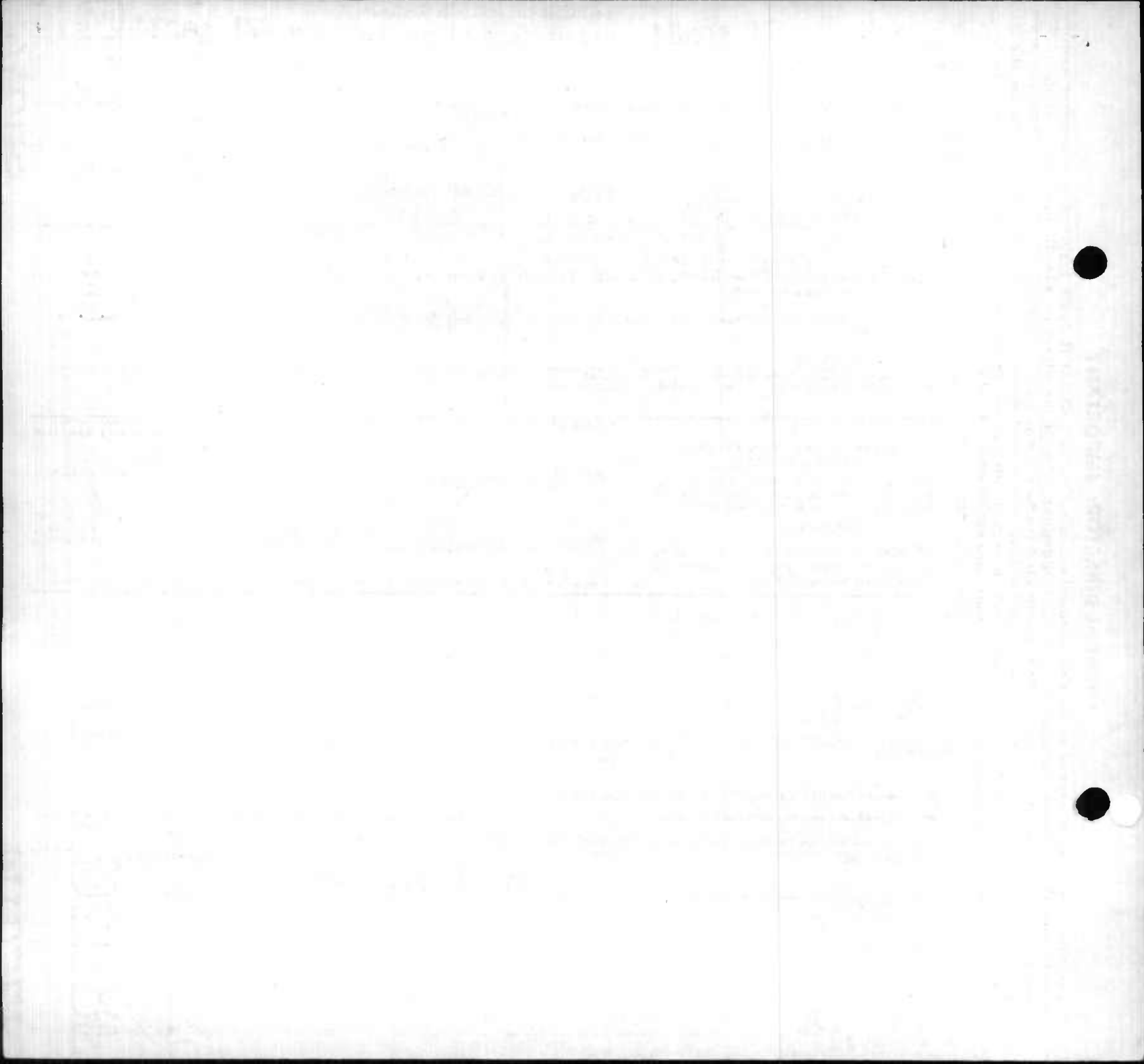


41-37-86 djs

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

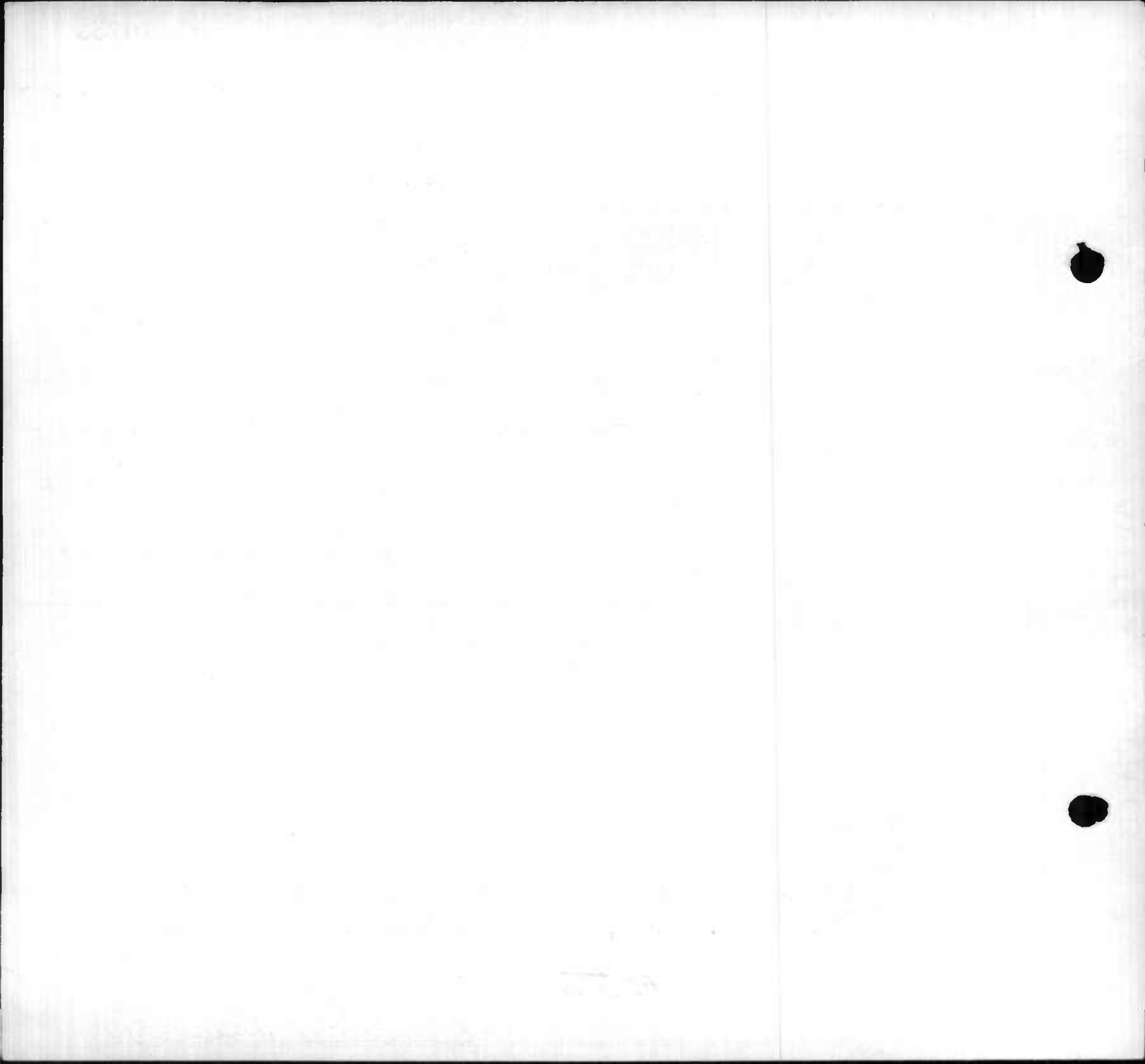
| B-600                                                                                                                                                                                                                                                                                                                                                       |                         | 71 10334                                                                                                                                                               |                                      | BALTIMORE CITY HEALTH DEPARTMENT                                                                                       |                                                                                                                | REG. NO. 71 10334                                                                             |                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                   |                         | 1. NAME OF DECEASED<br>(Type or Print) <i>Martha Berry</i>                                                                                                             |                                      | 2. DATE AND HOUR OF DEATH<br><i>10/29/71</i> <i>5:30</i> <i>A</i> M.                                                   |                                                                                                                |                                                                                               |                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                      |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>603</i>                                  |                                      | C. CITY OR TOWN <i>Baltimore</i>                                                                                       |                                                                                                                | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Baltimore City Hospital</i><br><i>4940 Eastern Avenue Baltimore, Maryland</i>                                                                                                                                                                                                                                    |                         | E. STREET AND NUMBER<br><i>413 N Collington Ave</i> <i>21224</i>                                                                                                       |                                      |                                                                                                                        |                                                                                                                |                                                                                               |                                               |
| 5. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                                     | 6. RACE<br><i>Negro</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><i>3/10/1920</i> | 9. AGE (In years last birthday)<br><i>51</i>                                                                           | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i> | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore, Md</i>                             | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i> |
| 13. FATHER'S NAME<br><i>Silas Norris</i>                                                                                                                                                                                                                                                                                                                    |                         | 14. MOTHER'S MAIDEN NAME<br><i>Hattie Cuckett</i>                                                                                                                      |                                      | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)<br><i>No</i> |                                                                                                                | 16. SOCIAL SECURITY NO.                                                                       |                                               |
| 17. INFORMANT<br><i>BCH RECORDS</i>                                                                                                                                                                                                                                                                                                                         |                         | ADDRESS<br><i>4940 Eastern Avenue Baltimore, Maryland 21224</i>                                                                                                        |                                      |                                                                                                                        |                                                                                                                |                                                                                               |                                               |
| 18. <i>303.21</i>                                                                                                                                                                                                                                                                                                                                           |                         | CAUSE OF DEATH                                                                                                                                                         |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                           |                                                                                                                |                                                                                               |                                               |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                              |                         | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Sepsisemic shock</i>                                                                                      |                                      | <i>48 hrs.</i>                                                                                                         |                                                                                                                |                                                                                               |                                               |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                              |                         | (B) <i>Gram (-) RUL pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                   |                                      | <i>60 hours</i>                                                                                                        |                                                                                                                |                                                                                               |                                               |
| (C) <i>Chronic alcoholism</i>                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                                        |                                      |                                                                                                                        |                                                                                                                |                                                                                               |                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                      |                         | <i>Alcoholism: H/O subarachnoid hemorrhage</i>                                                                                                                         |                                      | <i>6 yrs.</i>                                                                                                          |                                                                                                                |                                                                                               |                                               |
| 19A. DATE OF OPERATION<br><i>D</i>                                                                                                                                                                                                                                                                                                                          |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                       |                                      | 20A. AUTOPSY? (Yes or No)<br><i>No</i>                                                                                 |                                                                                                                | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                           |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                                |                                      | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                            |                                                                                                                |                                                                                               |                                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                              |                                      | 21F. HOW DID INJURY OCCUR?                                                                                             |                                                                                                                |                                                                                               |                                               |
| 22. I certify that (i) (this hospital) attended the deceased from <i>10/27</i> 19 <i>71</i> to <i>10/29</i> 19 <i>71</i><br>that (i) (we) last saw the deceased alive on <i>10/29</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                                        |                                      |                                                                                                                        |                                                                                                                |                                                                                               |                                               |
| 23A. SIGNATURE<br><i>P. Kurzweil</i>                                                                                                                                                                                                                                                                                                                        |                         | DEGREE                                                                                                                                                                 |                                      | 23B. DATE SIGNED<br><i>10/29/71</i>                                                                                    |                                                                                                                |                                                                                               |                                               |
| 23C. PHYSICIAN'S NAME (Type)<br><i>P. Kurzweil</i>                                                                                                                                                                                                                                                                                                          |                         | DEGREE                                                                                                                                                                 |                                      | 23D. ADDRESS<br><i>4940 Eastern Avenue Baltimore, Maryland</i><br><i>Balt. City Hosp</i> <i>21224</i>                  |                                                                                                                |                                                                                               |                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                   |                         | 24B. DATE<br><i>11-1-71</i>                                                                                                                                            |                                      | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Baltimore Natl</i>                                                            |                                                                                                                | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Md</i>                         |                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 9 1971</i>                                                                                                                                                                                                                                                                                                        |                         | 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor, M.D.</i>                                                                                                                |                                      | 25C. FUNERAL DIRECTOR<br><i>Edwin 10001 Brandyke</i>                                                                   |                                                                                                                | ADDRESS                                                                                       |                                               |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                        |                                        |                                                                                                                                                                                                 |                                                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| <p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>                                                                                                                                                                                                                                                                                                      |                                        | <p>REG. NO. <u>71 10335</u></p>                                                                                                                                                                 |                                                                                 |
| <p><b>BIRTH NO.</b> <u>L-000 71 10335</u></p>                                                                                                                                                                                                                                                                                                                                          |                                        | <p><b>2. DATE AND HOUR OF DEATH</b><br/><u>October 29, 1971 12:33 A.M.</u></p>                                                                                                                  |                                                                                 |
| <p><b>1. NAME OF DECEASED</b><br/>(Type or Print) <u>LEE, Della</u></p>                                                                                                                                                                                                                                                                                                                |                                        | <p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br/>A. STATE <u>Maryland</u><br/>B. COUNTY <u>703</u></p>                                       |                                                                                 |
| <p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br/><br/><u>33 The Johns Hopkins Hospital</u></p>                                                                                                                                                                                                                                                                     |                                        | <p><b>C. CITY OR TOWN</b> <u>Baltimore</u><br/><b>D. INSIDE CITY LIMITS?</b><br/>YES <input type="checkbox"/> NO <input type="checkbox"/></p>                                                   |                                                                                 |
| <p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location)<br/><u>The Johns Hopkins Hospital</u></p>                                                                                                                                                                                                                          |                                        | <p><b>E. STREET AND NUMBER</b><br/><u>902 Montford Avenue</u></p>                                                                                                                               |                                                                                 |
| <p><b>5. SEX</b><br/><u>Female</u></p>                                                                                                                                                                                                                                                                                                                                                 | <p><b>6. RACE</b><br/><u>Negro</u></p> | <p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br/><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p> | <p><b>8. DATE OF BIRTH</b><br/><u>2/7/99</u></p>                                |
| <p><b>9. AGE</b> (In years last birthday) <u>72</u></p>                                                                                                                                                                                                                                                                                                                                |                                        | <p><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p>                                                                                        | <p><b>11. BIRTHPLACE</b> (State or foreign country)<br/><u>Baltimore Md</u></p> |
| <p><b>12. CITIZEN OF WHAT COUNTRY?</b><br/><u>USA</u></p>                                                                                                                                                                                                                                                                                                                              |                                        | <p><b>13. FATHER'S NAME</b><br/><u>Henry Johnson</u></p>                                                                                                                                        |                                                                                 |
| <p><b>14. MOTHER'S MAIDEN NAME</b><br/><u>Julia</u></p>                                                                                                                                                                                                                                                                                                                                |                                        | <p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br/><u>no</u></p>                                                            |                                                                                 |
| <p><b>16. SOCIAL SECURITY NO.</b></p>                                                                                                                                                                                                                                                                                                                                                  |                                        | <p><b>17. INFORMANT</b><br/><u>William H Lee</u></p>                                                                                                                                            |                                                                                 |
| <p><b>18. CAUSE OF DEATH</b><br/><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br/>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br/><b>ANTECEDENT CAUSES</b><br/>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> |                                        | <p><b>(A) IMMEDIATE CAUSE</b> <u>Coronary Artery Disease</u><br/><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br/><u>HASCUO</u><br/><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b><br/><b>(C)</b></p>     |                                                                                 |
| <p><b>II</b><br/><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b><br/><u>old CVA; renal failure</u></p>                                                                                                                                                                                         |                                        | <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br/><u>30+ years</u><br/><u>30+ years</u><br/><u>3 years</u><br/><u>4 months</u></p>                                                     |                                                                                 |
| <p><b>19A. DATE OF OPERATION</b></p>                                                                                                                                                                                                                                                                                                                                                   |                                        | <p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>                                                                                                                                  |                                                                                 |
| <p><b>20A. AUTOPSY?</b> (Yes or No)<br/><u>NO</u></p>                                                                                                                                                                                                                                                                                                                                  |                                        | <p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>                                                                                                              |                                                                                 |
| <p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p>                                                                                                                                                                                                                                                                                    |                                        | <p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>                                                                                          |                                                                                 |
| <p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>                                                                                                                                                                                                                                                                                                 |                                        | <p><b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)</p>                                                                                                                         |                                                                                 |
| <p><b>21E. INJURY OCCURRED</b><br/>White At <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>                                                                                                                                                                                                                                                                    |                                        | <p><b>21F. HOW DID INJURY OCCUR?</b></p>                                                                                                                                                        |                                                                                 |
| <p><b>22. I certify that (1) (this hospital) attended the deceased from <u>Oct 1</u>, 19 <u>71</u> to <u>Oct 29</u>, 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>Oct. 29</u>, 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</b></p>           |                                        |                                                                                                                                                                                                 |                                                                                 |
| <p><b>23A. SIGNATURE</b><br/><u>Thomas K. Hodous, M.D.</u></p>                                                                                                                                                                                                                                                                                                                         |                                        | <p><b>23B. DATE SIGNED</b><br/><u>Oct 29, 1971</u></p>                                                                                                                                          |                                                                                 |
| <p><b>23C. PHYSICIAN'S NAME (Type)</b><br/><u>Thomas K. Hodous, M.D.</u></p>                                                                                                                                                                                                                                                                                                           |                                        | <p><b>23D. ADDRESS</b><br/><u>The Johns Hopkins Hospital</u></p>                                                                                                                                |                                                                                 |
| <p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br/><u>Burial</u></p>                                                                                                                                                                                                                                                                                                               |                                        | <p><b>24B. DATE</b><br/><u>11-3-71</u></p>                                                                                                                                                      |                                                                                 |
| <p><b>24C. NAME OF CEMETERY or CREMATORY</b><br/><u>Chatham Art</u></p>                                                                                                                                                                                                                                                                                                                |                                        | <p><b>24D. LOCATION</b> (City, town, or county) (State)<br/><u>Belts Md</u></p>                                                                                                                 |                                                                                 |
| <p><b>25A. DATE REC'D BY HEALTH DEPT.</b><br/><u>NOV 9 1971</u></p>                                                                                                                                                                                                                                                                                                                    |                                        | <p><b>25B. NAME OF REGISTRAR</b><br/><u>Valerie E. Taylor, R.D.</u></p>                                                                                                                         |                                                                                 |
| <p><b>25C. FUNERAL DIRECTOR</b><br/><u>Condon 1000 Brantly</u></p>                                                                                                                                                                                                                                                                                                                     |                                        | <p><b>ADDRESS</b></p>                                                                                                                                                                           |                                                                                 |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Williams, Foster

2. DATE AND HOUR OF DEATH

11/5/71

110:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

University of Maryland Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

1601

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

942 Harlem Ave. Balto 21217

5. SEX

M

6. RACE

B

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

10/31/17

9. AGE (In years  
last birthday)

54

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Work for Bethlehem Steel

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

Elijah Williams

14. MOTHER'S MAIDEN NAME

Georgia Foster

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

Yes

(If yes, give war or dates of service)

WW 2 - 11/24/41 to

16. SOCIAL  
SECURITY NO.

213 12 8726

17. INFORMANT

Wife

ADDRESS

18.

410.9 10/2/45

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE Sinus arrest; MI failure  
DUE TO, OR AS A CONSEQUENCE OF:APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 month

(B) Myocardial Infarction  
DUE TO, OR AS A CONSEQUENCE OF:

(C) Atherosclerotic Heart disease

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Renal failure

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ~~11/1~~ 10/6/71 19 71 to 11/5 19 71  
that (I) (we) last saw the deceased alive on 11/5 19 71 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Michael F. Graham MD

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

11/5/71

23C. PHYSICIAN'S  
NAME (Type)

Michael F. GRAHAM

23D. ADDRESS

22 S. Green St.

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

11-9-71

Catholics Arch

Catholics Arch

Catholics Arch

Catholics Arch

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

NOV 9 1971

Robert E. Farber, R.D.

Edw. Wilson 1001 Broadway

11/24/71 - Correction form from funeral director.

*ABC*  
*Exxon*

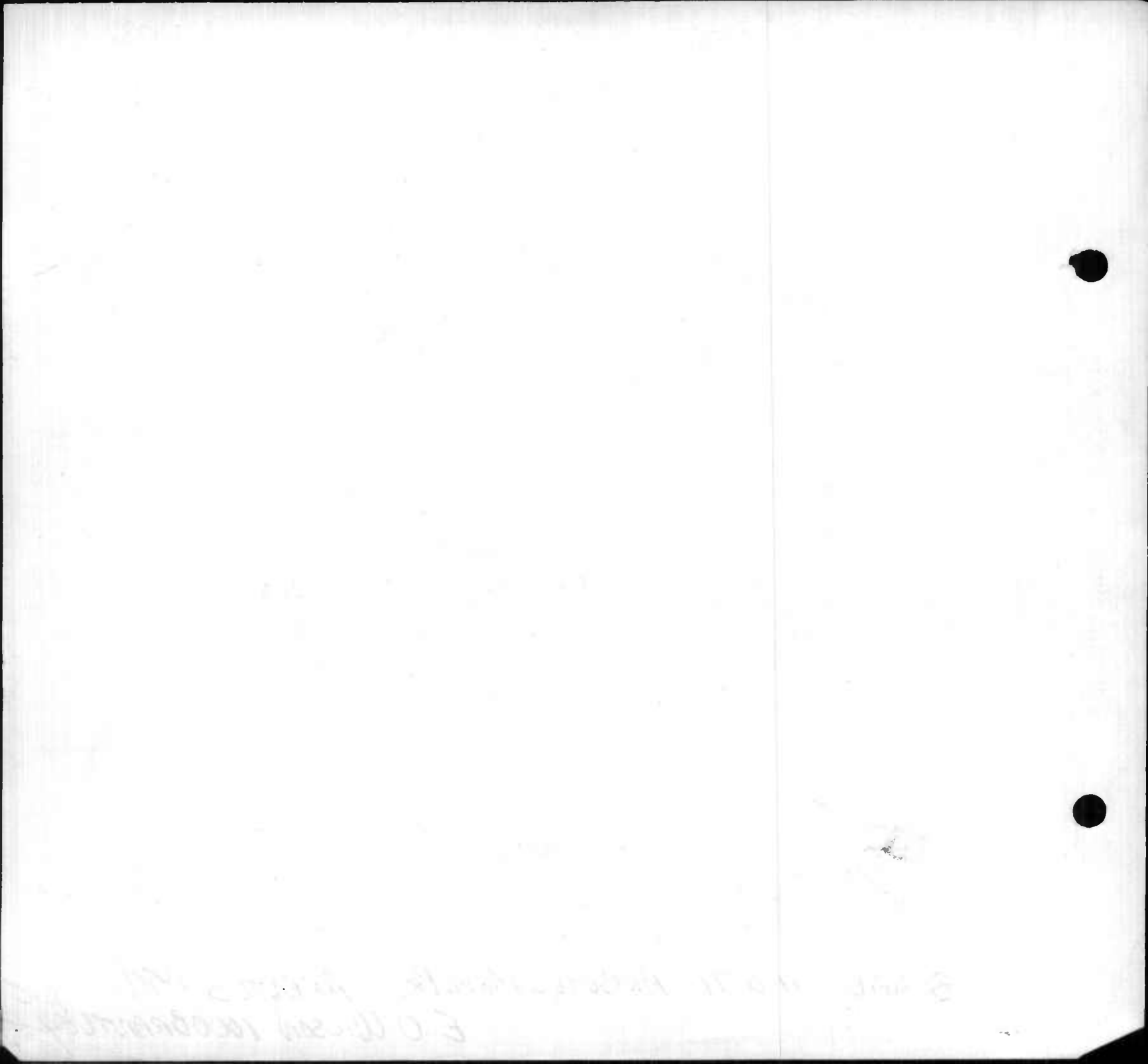
11/24/71 - Letter from University Hospital.

*ABC*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | REG. NO. <b>71 10337</b>                                                                                                              |  |
| C-435 (MNY) 10337                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | CERTIFICATE OF DEATH                                                                                                                  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>LORETTA GLADYS COLLETON</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 2. DATE AND HOUR OF DEATH<br><b>31 OCT 1971 8:50 A.M.</b>                                                                             |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>UNIVERSITY of Maryland Hospital</b><br><b>38</b>                                                                                                                                                                                                                                       |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY <b>2843</b> |  |
| 5. SEX <b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 6. RACE <b>NEG</b>                                                                                                                    |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                          |  | 8. DATE OF BIRTH <b>4-10-50</b>                                                                                                       |  |
| 9. AGE (In years last birthday) <b>21</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10. Under 1 Yr. Months: Days: Hours: Min.                                                                                             |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>STUDENT</b>                                                                                                                                                                                                                                                                                                                                                        |  | 10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>                                                                                            |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>                                                                                             |  |
| 13. FATHER'S NAME<br><b>Phineas COLLETON</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 14. MOTHER'S MAIDEN NAME<br><b>Clara McRAY</b>                                                                                        |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.                                                                                                               |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | ADDRESS                                                                                                                               |  |
| 18. <b>567.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br><b>Cardiac Arrest</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Renal Failure</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Gangrene of Small Bowel</b><br>(C) <b>Vacuum Encephalopathy</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 hrs</b><br><b>10 days</b><br><b>12 days</b><br><b>10 days</b>                |  |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |
| 19A. DATE OF OPERATION<br><b>1900-171</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Gangrene of Small Bowel</b>                                                    |  |
| 20A. AUTOPSY (Yes or No) <b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                              |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                             |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                             |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                            |  | 21F. HOW DID INJURY OCCUR?                                                                                                            |  |
| 22. I certify that <del>he</del> (this hospital) attended the deceased from <b>20 OCT 71</b> to <b>31 OCT 1971</b> that (I) <del>last</del> last saw the deceased alive on <b>31 OCT 1971</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did) <del>not</del> view the body after death.                                                                                       |  |                                                                                                                                       |  |
| 23A. SIGNATURE<br><b>Walker Robinson, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 23B. DATE SIGNED<br><b>31 OCT 71</b>                                                                                                  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>WALKER LEE ROBINSON MD</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  | 23D. ADDRESS<br><b>University of Maryland Hosp.</b>                                                                                   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  | 24B. DATE<br><b>11-3-71</b>                                                                                                           |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEM. PK</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 24D. LOCATION (City, town, or county) (State)<br><b>ARBUTUS MD.</b>                                                                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 9 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 25B. NAME OF REGISTRAR<br><b>Chas. J. ...</b>                                                                                         |  |
| 25C. FUNERAL DIRECTOR<br><b>E. O. Wilson</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | ADDRESS<br><b>1000 BRANTLEY</b>                                                                                                       |  |





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10338

BIRTH NO. 71 10338

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>JAMES ROGERS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> <span style="float: right;">M.</span>                                            |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>221 N. Fremont Ave. Apt. 403</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>11 1 1971 9:05a</b> <span style="float: right;">M.</span>                                                                           |  |
| 6. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 7. RACE<br><b>negro</b>                                                                                                                                                                  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | C. CITY OR TOWN<br><b>Balto.</b>                                                                                                                                                         |  |
| 9. DATE OF BIRTH<br><b>7/6/23</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10. AGE (in years last birthday)<br><b>46</b>                                                                                                                                            |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>David Rogers</b>                                                                                                                                      |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME<br><b>Addie</b>                                                                                                                                                 |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 17. SOCIAL SECURITY NO.<br><b>215-18-9677</b>                                                                                                                                            |  |
| 18. INFORMANT<br><b>Mrs. Nelson, Same</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | ADDRESS                                                                                                                                                                                  |  |
| 19. <b>492A</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                       |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br><b>Pulmonary emphysema and fibrosis</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                         |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                 |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 22F. HOW DID INJURY OCCUR?                                                                                                                                                               |  |
| 23.<br>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br><br>ACTUAL SIGNATURE<br><b>Russell S. Fisher, M.D.</b><br>EXAMINER'S NAME (Type)<br><b>Russell S. Fisher, M.D.</b><br><br>CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br><br>DATE SIGNED<br><b>11-1-71</b> |  |                                                                                                                                                                                          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 24B. DATE<br><b>11/6/71</b>                                                                                                                                                              |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>MT Calvary Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 24D. LOCATION (City, town, or county) (State)<br><b>A A County Md</b>                                                                                                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 9 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>                                                                                                                                  |  |
| 25C. FUNERAL DIRECTOR<br><b>Adolphus Halstead</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | ADDRESS<br><b>1206 W North Ave</b>                                                                                                                                                       |  |

Letter from M.E.'s office

12-10-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |               |                                                                                                                                                             |                                                                                                                                                                                                                                                                                             | 71 10339                                                                 |                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |               |                                                                                                                                                             |                                                                                                                                                                                                                                                                                             | REG. NO. 71 10339                                                        |                                          |
| BIRTH NO. 71 10339                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               | 1. NAME OF DECEASED<br>(Type or Print) Alice Squirrel                                                                                                       |                                                                                                                                                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br>11/3/71 10 <sup>40</sup> P.M.               |                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Bolton Hill Nursing Home<br>1400 JOHN ST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |               |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE Maryland<br>B. COUNTY<br>C. CITY OR TOWN Baltimore<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 2122 Eddings St. |                                                                          |                                          |
| 5. SEX Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 6. RACE Black | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/11/20                                                                                                                                                                                                                                                                   | 9. AGE (In years last birthday) 51 YRS.                                  | 10. Under 1 Yr. Months Days Hours Min.   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |               | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                                                                                                                                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country) Maryland                       |                                          |
| 13. FATHER'S NAME Albert Squirrel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               |                                                                                                                                                             | 12. CITIZEN OF WHAT COUNTRY? U.S.                                                                                                                                                                                                                                                           |                                                                          |                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |               | 16. SOCIAL SECURITY NO. 214-18-6233                                                                                                                         |                                                                                                                                                                                                                                                                                             | 17. INFORMANT Lillian Admission Record                                   |                                          |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>19A. DATE OF OPERATION 0<br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>20A. AUTOPSY? (Yes or No)<br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |               |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>yes<br>years<br>years<br>years                                                                                                                                                                                                              |                                                                          |                                          |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                          |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |               | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                                                                                                             | 21F. HOW DID INJURY OCCUR?                                               |                                          |
| 22. I certify that (I) (this hospital) attended the deceased from 12/14 1970 to 11/3 1971 that (I) (we) last saw the deceased alive on 11/3 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                                                                                                                 |               |                                                                                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                          |                                          |
| 23A. SIGNATURE [Signature]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |               |                                                                                                                                                             | 23B. DATE SIGNED 11/4/71                                                                                                                                                                                                                                                                    |                                                                          | 23C. PHYSICIAN'S NAME (Type) [Signature] |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |               | 24B. DATE 11/9/71                                                                                                                                           |                                                                                                                                                                                                                                                                                             | 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery                  |                                          |
| 24D. LOCATION A A County Md                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |               | 25A. DATE REG. BY HEALTH DEPT. NOV 9 1971                                                                                                                   |                                                                                                                                                                                                                                                                                             | 25B. NAME OF REGISTRAR Robert E. Farber, M.D.                            |                                          |
| 25C. FUNERAL DIRECTOR Adolphus Halstead                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |               | 25D. ADDRESS 1206 W North Ave                                                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                          |                                          |

2122 ETTINGST

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. **71 10340**

BIRTH NO. **71 10340**

1. NAME OF DECEASED  
(Type or Print)

**Mark, Henry John**

2. DATE AND HOUR OF DEATH

**11/8/71**

**12:20**

A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

**George Washington Nursing Hm.  
607 Pennsylvania Avenue  
Baltimore, Maryland 21201**

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

**Maryland**

C. CITY OR TOWN

**Baltimore**

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

**410 W. Franklin Street**

5. SEX

**Male**

6. RACE

**Caucasian**

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

**6/17/80**

9. AGE (In years last birthday)

**91 yrs.**

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Brick Layer**

10B. KIND OF BUSINESS OR INDUSTRY

**Block mason**

11. BIRTHPLACE (State or foreign country)

**Massachusetts**

12. CITIZEN OF WHAT COUNTRY?

**U. S. A.**

13. FATHER'S NAME

**John Henry Mark**

14. MOTHER'S MAIDEN NAME

**Emma**

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

**Unknown**

16. SOCIAL SECURITY NO.

**056-09-8577-A**

17. INFORMANT

**Chart**

ADDRESS

18. **486X1**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

**Pneumonia**

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**3 days**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

**0**

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

**No**

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

**None**

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **Jan 19 19 20** to **Nov 8 19 71** that (I) (we) last saw the deceased alive on **Nov. 8 19 71** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

**H. E. Bondy**

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

**Nov. 9, 1971**

23C. PHYSICIAN'S NAME (Type)

**H. E. Bondy**

DEGREE

23D. ADDRESS

**607 Penns Ave. Bk. Hs. Md.**

24A. BURIAL CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**11/10/71**

24C. NAME of CEMETERY or CREMATORY

**Mt. Calvary Cemetery**

24D. LOCATION

**A A County Md**

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

**NOV 9 1971**

25B. NAME OF REGISTRAR

**Robert E. Taylor, M.D.**

25C. FUNERAL DIRECTOR

**Alstead 1206 W**

ADDRESS

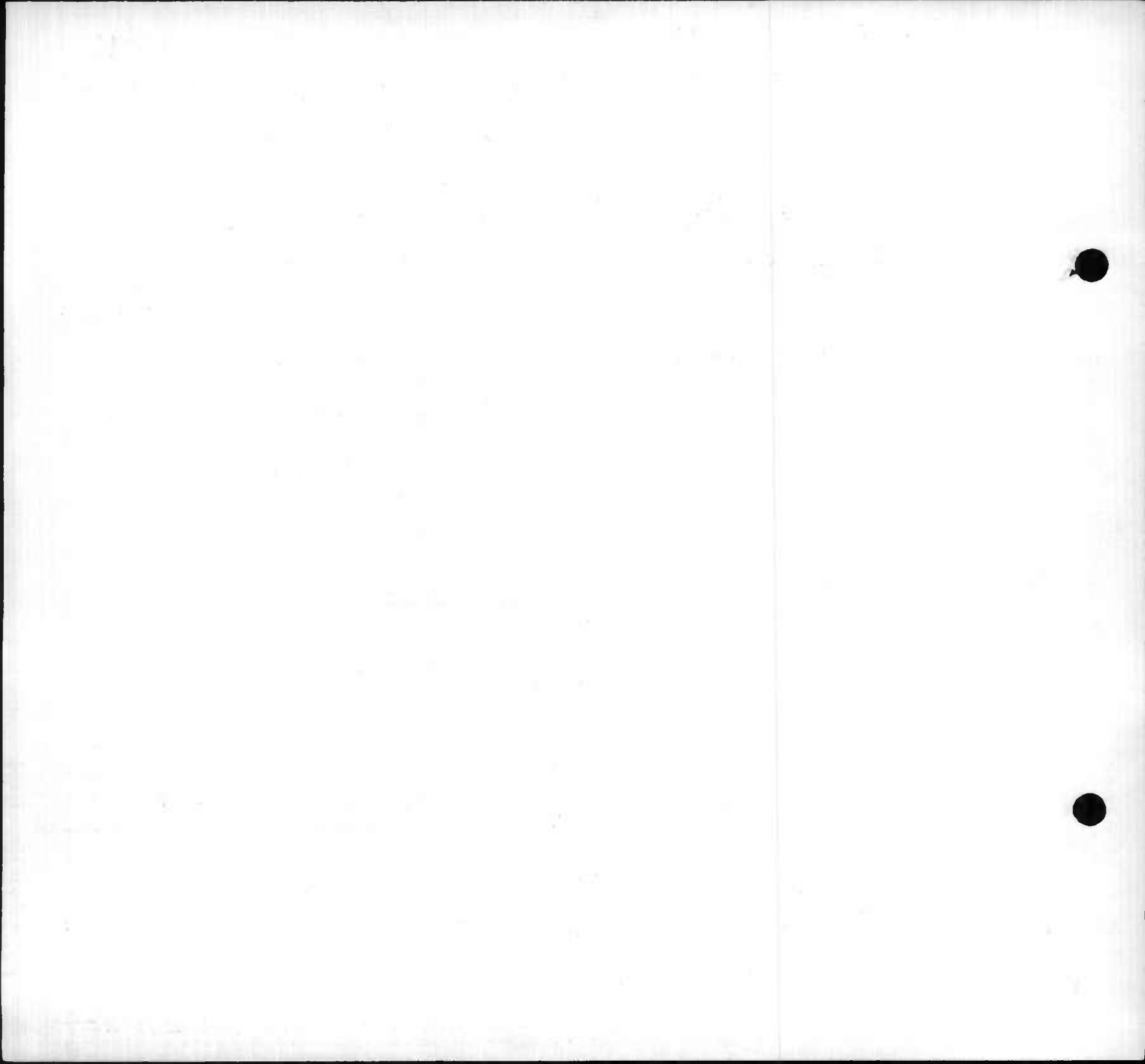
**North Ave**



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 71 10341                                                                                                                                                                                                                                                                                                                         |               | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                           |                            | REG. NO. 71 10341                                                                                                                  |                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) MILDRED V. GREENE                                                                                                                                                                                                                                                                                   |               | 2. DATE AND HOUR OF DEATH<br>NOVEMBER 9, 1971 3:30 A.M.                                                                                                                                                                                                                                            |                            |                                                                                                                                    |                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>LUTHERAN HOSPITAL OF 46 MARYLAND, INC.                                                                                                                              |               | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE MARYLAND 21225 B. COUNTY 2552<br>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 501 BRIDGEVIEW RD. |                            |                                                                                                                                    |                                                             |
| 5. SEX FEMALE                                                                                                                                                                                                                                                                                                                              | 6. RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                        | 8. DATE OF BIRTH 4.24.1916 | 9. AGE (In years last birthday) 55                                                                                                 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CROSSING GUARD                                                                                                                                                                                                                                 |               | 10B. KIND OF BUSINESS OR INDUSTRY BALTO. CITY                                                                                                                                                                                                                                                      |                            | 11. BIRTHPLACE (State or foreign country) VA                                                                                       |                                                             |
| 12. CITIZEN OF WHAT COUNTRY? AMERICA                                                                                                                                                                                                                                                                                                       |               | 13. FATHER'S NAME THOMAS H. COATES                                                                                                                                                                                                                                                                 |                            | 14. MOTHER'S MAIDEN NAME SARAH ELLIOTT                                                                                             |                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                   |               | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                            |                            | 17. INFORMANT ADDRESS<br>GEORGE GREENE 501 Bridgeview Rd                                                                           |                                                             |
| 18. 199.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |               | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF:<br>(B) TERMINAL MALIGNANCY DUE TO, OR AS A CONSEQUENCE OF:<br>(C)                                                                                                                                             |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 months.                                                                            |                                                             |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                        |               |                                                                                                                                                                                                                                                                                                    |                            |                                                                                                                                    |                                                             |
| 19A. DATE OF OPERATION 6.27.70                                                                                                                                                                                                                                                                                                             |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CANCER STOMACH                                                                                                                                                                                                                                    |                            | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                                      |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                           |                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                           |                                                             |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                  |               | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                             |                            | 21F. HOW DID INJURY OCCUR?                                                                                                         |                                                             |
| 22. I certify that (I) (this hospital) attended the deceased from 10-26-1971 to 11-9-1971 that (I) (we) last saw the deceased alive on 11-8-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                  |               |                                                                                                                                                                                                                                                                                                    |                            |                                                                                                                                    |                                                             |
| 23A. SIGNATURE [Signature] M.D.                                                                                                                                                                                                                                                                                                            |               | 23B. DATE SIGNED 11.9.71                                                                                                                                                                                                                                                                           |                            | 23C. PHYSICIAN'S NAME (Type) S. J. EDWIN, M.D.                                                                                     |                                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                            |               | 24B. DATE 11-13-71                                                                                                                                                                                                                                                                                 |                            | 24C. NAME of CEMETERY or CREMATORY CEDAR HILL CEM.                                                                                 |                                                             |
| 24D. LOCATION Anne Arundel Cty. Md.                                                                                                                                                                                                                                                                                                        |               | 24E. NAME OF REGISTRAR Wm. C. MARCH                                                                                                                                                                                                                                                                |                            | 24F. FUNERAL DIRECTOR ADDRESS 928 E NORTH                                                                                          |                                                             |
| 25A. DATE RECD BY HEALTH DEPT. NOV 9 1971                                                                                                                                                                                                                                                                                                  |               | 25B. NAME OF REGISTRAR                                                                                                                                                                                                                                                                             |                            | 25C. FUNERAL DIRECTOR ADDRESS                                                                                                      |                                                             |





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                       |  | REG. NO. 71 10342                                                                                                                                           |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| B-500                                                                                                                                                                                                                                        |  | 71 10342                                                                                                                                                                                                                                                                                                                                                                                                              |  | CERTIFICATE OF DEATH                                                                                                                                        |  |
| BIRTH NO.                                                                                                                                                                                                                                    |  | 1. NAME OF DECEASED<br>(Type or Print) <b>BOWEN, RAYMOND</b>                                                                                                                                                                                                                                                                                                                                                          |  | 2. DATE AND HOUR OF DEATH<br>November 6, 1971 12:20 P.M.                                                                                                    |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                       |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2609</b>                                                                                                                                                                                                                                                                            |  |                                                                                                                                                             |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>31</b><br><b>BALTIMORE CITY HOSPITALS</b><br><b>4940 Eastern Avenue</b><br><b>Baltimore, Maryland 21224</b>                                                                                       |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                               |  |
| 5. SEX <b>Female</b>                                                                                                                                                                                                                         |  | 6. RACE <b>Caucasian</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><b>9-20-00</b>                                                                                                                                                                                                           |  | 9. AGE (in years last birthday)<br><b>71 Yrs.</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 10. Under 1 Yr. Months Days<br>11. Under 24 Hrs. Hours Min.                                                                                                 |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>                                                                                                                                |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>PLUMBER</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                   |  | 13. FATHER'S NAME<br><b>? BOWEN</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 14. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>                                                                                                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES W.W.I.</b>                                                                                                                |  | 16. SOCIAL SECURITY NO.<br><b>213-12-0441</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 17. INFORMANT<br><b>BCH-RECORDS</b> ADDRESS<br><b>4940 Eastern Avenue</b><br><b>Baltimore, Maryland 21224</b>                                               |  |
| 18. <b>5322</b>                                                                                                                                                                                                                              |  | CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ACUTE MYOCARDIAL INFARCTION 25 MIN.</b> |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                             |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>PERITONITIS</b>                                                                                         |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                                                                                                   |  | <b>1 WEEK</b>                                                                                                                                               |  |
|                                                                                                                                                                                                                                              |  | (C) <b>GASTROINTESTINAL HEMORRHAGE &amp; PERFORATION</b>                                                                                                                                                                                                                                                                                                                                                              |  | <b>1 WEEK</b>                                                                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>CHRONIC LUNG DISEASE; PNEUMONIA</b>                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                             |  |
| 19A. DATE OF OPERATION<br><b>11-1-71; 11-6-71</b>                                                                                                                                                                                            |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>(1) PERF. DUOD. ULCER (2) TRACH.</b>                                                                                                                                                                                                                                                                                                                           |  | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>                                                                                                                     |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b>                                                                                                                                                           |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                    |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>NO</b>                                                       |  |
| 21C. WHERE DID INJURY OCCUR?<br><b>NO</b>                                                                                                                                                                                                    |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                          |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  |
| 21F. HOW DID INJURY OCCUR?<br><b>NO</b>                                                                                                                                                                                                      |  | 22. I certify that <del>(if this hospital)</del> attended the deceased from <b>30 October</b> 19 <b>71</b> to <b>6 November</b> 19 <b>71</b><br>that <del>(N)</del> (we) last saw the deceased alive on <b>6 November</b> 19 <b>71</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(N)</del> (We) (did) (did not) view the body after death. |  |                                                                                                                                                             |  |
| 23A. SIGNATURE<br><b>Karl Stecher, Jr., M.D.</b>                                                                                                                                                                                             |  | 23B. DATE SIGNED<br><b>11-6-71</b>                                                                                                                                                                                                                                                                                                                                                                                    |  | 23C. PHYSICIAN'S NAME (Type)<br><b>Karl Stecher MD</b>                                                                                                      |  |
| 23D. ADDRESS<br><b>Baltimore City Hospitals 4940 Eastern Ave 21224</b>                                                                                                                                                                       |  | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                             |  | 24B. DATE<br><b>11-9-71</b>                                                                                                                                 |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>MT. CARMEL CEM.</b>                                                                                                                                                                                 |  | 24D. LOCATION<br><b>5712 O'DONNELL ST. BALTO., 24, MD.</b>                                                                                                                                                                                                                                                                                                                                                            |  | 24E. STATE<br><b>MD.</b>                                                                                                                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 9 1971</b>                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Jaber, R.D.</b>                                                                                                                                                                                                                                                                                                                                                                |  | 25C. FUNERAL DIRECTOR<br><b>Charles J. Jaber</b>                                                                                                            |  |
| 25D. ADDRESS<br><b>901 S. CONNING ST. BALTO., 21224, MD.</b>                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                             |  |

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1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808



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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                      |  | 71 10343                                                                                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|
| R-246                                                                                                                                                                                                                                                                                                                 |  | 71 10343                                                                                 |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                             |  | REG. NO.                                                                                 |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                |  | 2. DATE AND HOUR OF DEATH                                                                |  |
| FRANCES P. ROESLER                                                                                                                                                                                                                                                                                                    |  | November 7, 1971 9:45 P. M.                                                              |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)    |  |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                                                  |  | A. STATE                                                                                 |  |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION                                                                                                                                                                                                                                                    |  | B. COUNTY                                                                                |  |
| 35 Church Home and Hospital D.O.A.                                                                                                                                                                                                                                                                                    |  | Md.                                                                                      |  |
| 5. SEX                                                                                                                                                                                                                                                                                                                |  | C. CITY OR TOWN                                                                          |  |
| Female                                                                                                                                                                                                                                                                                                                |  | Baltimore                                                                                |  |
| 6. RACE                                                                                                                                                                                                                                                                                                               |  | D. INSIDE CITY LIMITS?                                                                   |  |
| White                                                                                                                                                                                                                                                                                                                 |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                                                                                                                                                                                                                 |  | E. STREET AND NUMBER                                                                     |  |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                    |  | 906 S. Belnord Ave. # 21224.                                                             |  |
| 8. DATE OF BIRTH                                                                                                                                                                                                                                                                                                      |  | 9. AGE (In years last birthday)                                                          |  |
| Apr. 6, 1906                                                                                                                                                                                                                                                                                                          |  | 65                                                                                       |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                           |  | 11. BIRTHPLACE (State or foreign country)                                                |  |
| House Work                                                                                                                                                                                                                                                                                                            |  | Baltimore, Md.                                                                           |  |
| 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                     |  | 12. CITIZEN OF WHAT COUNTRY?                                                             |  |
| At Home                                                                                                                                                                                                                                                                                                               |  | U.S.A.                                                                                   |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                     |  | 14. MOTHER'S MAIDEN NAME                                                                 |  |
| George N. Price                                                                                                                                                                                                                                                                                                       |  | Mary Myers                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) If yes, give war or dates of service                                                                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.                                                                  |  |
| No                                                                                                                                                                                                                                                                                                                    |  | NONE                                                                                     |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                         |  | ADDRESS                                                                                  |  |
| Garland F. Roesler                                                                                                                                                                                                                                                                                                    |  | Same.                                                                                    |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                    |  | CAUSE OF DEATH                                                                           |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                          |  | ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE                                                  |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                     |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                             |  | (B) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF:                                    |  |
|                                                                                                                                                                                                                                                                                                                       |  | (C)                                                                                      |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                      |  | CHRONIC PYELONEPHRITIS                                                                   |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  |
| 0                                                                                                                                                                                                                                                                                                                     |  | NONE                                                                                     |  |
| 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                             |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                     |  |
| NO                                                                                                                                                                                                                                                                                                                    |  |                                                                                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                 |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  |
| NO ACCIDENT                                                                                                                                                                                                                                                                                                           |  |                                                                                          |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                              |  | 21D. TIME OF INJURY (APPROX.)                                                            |  |
|                                                                                                                                                                                                                                                                                                                       |  |                                                                                          |  |
| 21E. INJURY OCCURRED                                                                                                                                                                                                                                                                                                  |  | 21F. HOW DID INJURY OCCUR?                                                               |  |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                     |  |                                                                                          |  |
| 22. I certify that (I) (this hospital) attended the deceased from JULY 19 67 to PRESENT TIME 19 71 that (I) (we) last saw the deceased alive on OCT. 29 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. |  |                                                                                          |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                        |  | 23B. DATE SIGNED                                                                         |  |
| J. Davis M.D.                                                                                                                                                                                                                                                                                                         |  | 11-9-71                                                                                  |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                          |  | 23D. ADDRESS                                                                             |  |
| PAUL J. DAVIS M.D.                                                                                                                                                                                                                                                                                                    |  | BALTIMORE CITY HOSPITALS                                                                 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                              |  | 24B. DATE                                                                                |  |
| Burial                                                                                                                                                                                                                                                                                                                |  | 11-71                                                                                    |  |
| 24C. NAME OF CEMETERY or CREMATORY                                                                                                                                                                                                                                                                                    |  | 24D. LOCATION (City, town, or county) (State)                                            |  |
| Carmel Cemetery                                                                                                                                                                                                                                                                                                       |  | 5712 O'Donnell St., Balto., 24, Md.                                                      |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                       |  | 25B. NAME OF REGISTRAR                                                                   |  |
| NOV 9 1971                                                                                                                                                                                                                                                                                                            |  | Charles J. Seiler                                                                        |  |
| 25C. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                 |  | ADDRESS                                                                                  |  |
| Charles J. Seiler                                                                                                                                                                                                                                                                                                     |  | 901 S. Conkling St. Balto., 21224, Md.                                                   |  |

NOTES ON THE HISTORY OF THE  
CITY OF CHICAGO

THE CITY OF CHICAGO

THE CITY OF CHICAGO

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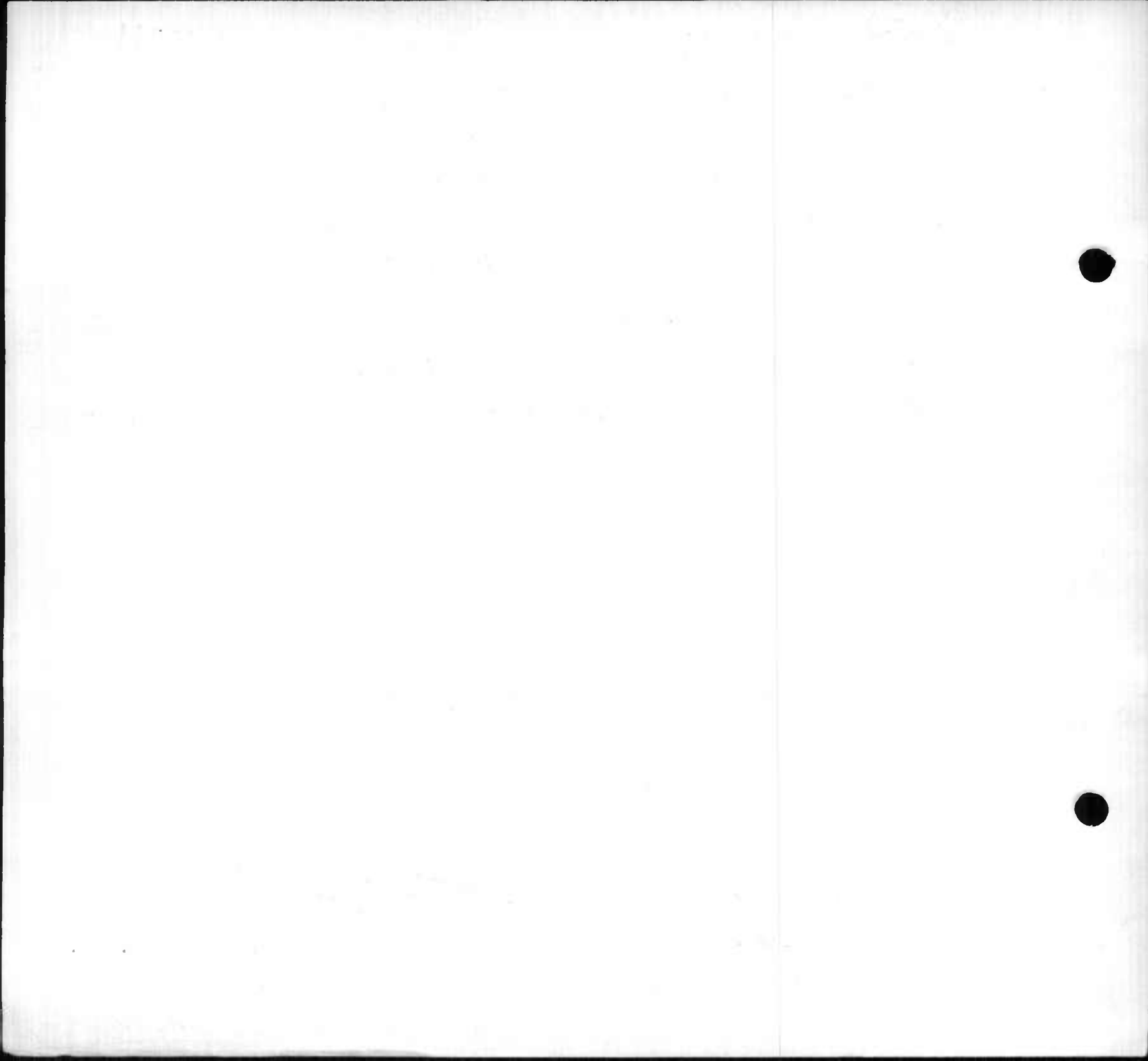
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             |                                                                                                                                    | REG. NO. <b>71 10344</b>                                                  |                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| BIRTH NO. <b>D-540</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |                     | <b>71 10344</b>                                                                                                                                             |                                                                                                                                    |                                                                           |                                                                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ELSIE OLGA DONNELLY</b>                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>11-7-71 1:10 P.M.</b>                                                                              |                                                                           |                                                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>2505</b> |                                                                           |                                                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>3615 FAIRHAVEN AVE. BALTO. MD. 21226</b>                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                |                                                                           | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             | E. STREET AND NUMBER<br><b>3615 FAIRHAVEN AVE.</b>                                                                                 |                                                                           |                                                                                               |
| 5. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                             | 6. RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-4-19</b>                                                                                                 | 9. AGE (In years last birthday)<br><b>52</b>                              | 10. Under 1 Yr. Months Days<br>11. Under 24 Hrs. Hours Min.                                   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CASHIER</b>                                                                                                                                                                                                                                                                                                                                  |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>INS.</b>                                                                                                            |                                                                                                                                    | 11. BIRTHPLACE (State or foreign country)<br><b>BALTO. MD.</b>            |                                                                                               |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             | 13. FATHER'S NAME<br><b>HARRY BOYKO</b>                                                                                            |                                                                           |                                                                                               |
| 14. MOTHER'S MAIDEN NAME<br><b>MOSCAL</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                             | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>              |                                                                           |                                                                                               |
| 16. SOCIAL SECURITY NO.<br><b>213-12-2927</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             | 17. INFORMANT<br><b>Husband. 3615 FAIRHAVEN AVE.</b>                                                                               |                                                                           |                                                                                               |
| 18. CAUSE OF DEATH<br><b>183.01</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Generalized carcinomatous 18 months</b><br><b>Ovarian cancer</b> |                     |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>18 months</b>                                                                   |                                                                           |                                                                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |                                                                                                                                    |                                                                           |                                                                                               |
| 19A. DATE OF OPERATION<br><b>Nov. 3, 1970</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ovarian cyst/malignant</b>                                                                           |                                                                                                                                    | 20A. AUTOPSY? (Yes or No) <b>NO</b>                                       |                                                                                               |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                             |                                                                                                                                    |                                                                           |                                                                                               |
| 21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                       |                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |                                                                                                                                    |                                                                           |                                                                                               |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                      |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                    | 21F. HOW DID INJURY OCCUR?                                                |                                                                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 6</b> 19 <b>71</b> to <b>11-7-71</b> and that (I) (we) last saw the deceased alive on <b>Nov. 6</b> 19 <b>71</b> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                           |                     |                                                                                                                                                             |                                                                                                                                    |                                                                           |                                                                                               |
| 23A. SIGNATURE<br><b>Dr Imre Neubauer MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             | 23B. DATE SIGNED<br><b>11-8-71</b>                                                                                                 |                                                                           |                                                                                               |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Dr Imre Neubauer MD.</b>                                                                                                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                             | 23D. ADDRESS<br><b>936 Patapsco Avenue, Balto. Md.</b>                                                                             |                                                                           |                                                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                      |                     | 24B. DATE<br><b>11-10-71</b>                                                                                                                                |                                                                                                                                    | 24C. NAME of CEMETERY or CREMATORY<br><b>Holy Cross</b>                   |                                                                                               |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTO. MD.</b>                                                                                                                                                                                                                                                                                                                                                                             |                     | 24E. FUNERAL DIRECTOR<br><b>HAHR Funeral Home 4200 PENNINGTON</b>                                                                                           |                                                                                                                                    |                                                                           |                                                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 9 1971</b>                                                                                                                                                                                                                                                                                                                                                                                           |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Barber, M.D.</b>                                                                                                     |                                                                                                                                    | 25C. FUNERAL DIRECTOR ADDRESS<br><b>HAHR Funeral Home 4200 PENNINGTON</b> |                                                                                               |



71 10345

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10345

BIRTH NO.

HOCHSTAFEL

1. NAME OF DECEASED  
(Type or Print)

Ella Hochstafel

2. DATE  
OF  
DEATHKnown ☐ Month Day Year Hour  
Estimated ☒ 11 6 71 940 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(If not in hospital or institution, give street  
address or location)

001503 Byrd St.

3. DATE  
PRONOUNCED DEADMonth Day Year Hour  
11 6 71 940 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

MD

2404

6. SEX

F

7. RACE

Wh

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

April 3, 1898

10. AGE (In years  
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1503 Byrd St

11. BIRTHPLACE (State or foreign country)

Alabama

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Evans

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

House

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

267 20 8883

18. INFORMANT

ADDRESS

John Hochstafel 1503 Byrd Street Balto. 30

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic

Cardiovascular Disease

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

NO

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz

Deputy  
M.D.CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11. 7. 71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11 9 71

24C. NAME OF CEMETERY or CREMATORY

Cedar Hill Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 9 1971

25B. NAME OF REGISTRAR

Robert E. Barber, M.D.

25C. FUNERAL DIRECTOR

McGully Funeral Home

ADDRESS

130 East Fort Avenue  
Balto. 12 21230

1901

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE

APRIL 1, 1899

ALBANY:

JOHN B. LANE, PRINTER

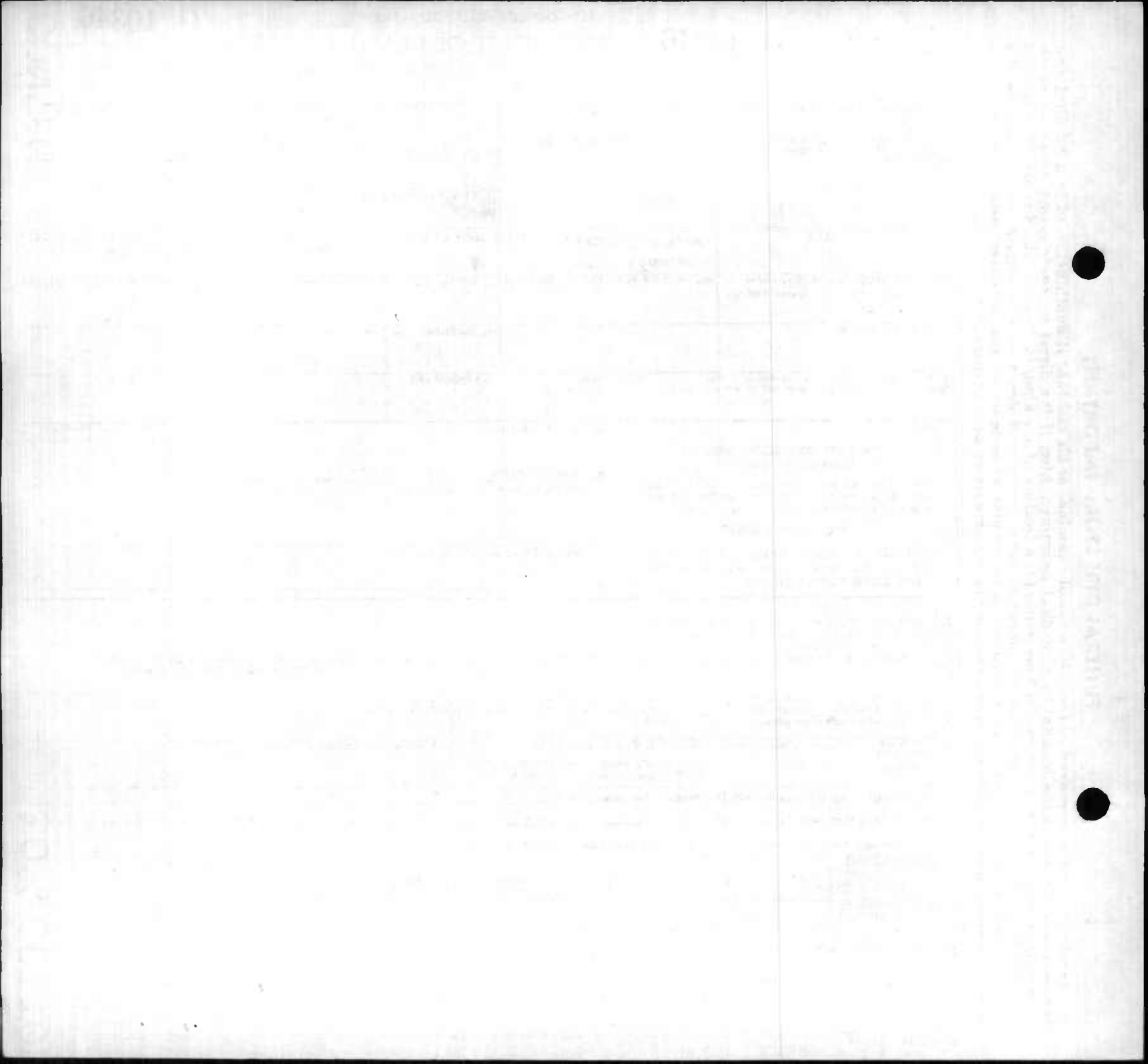
1901



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

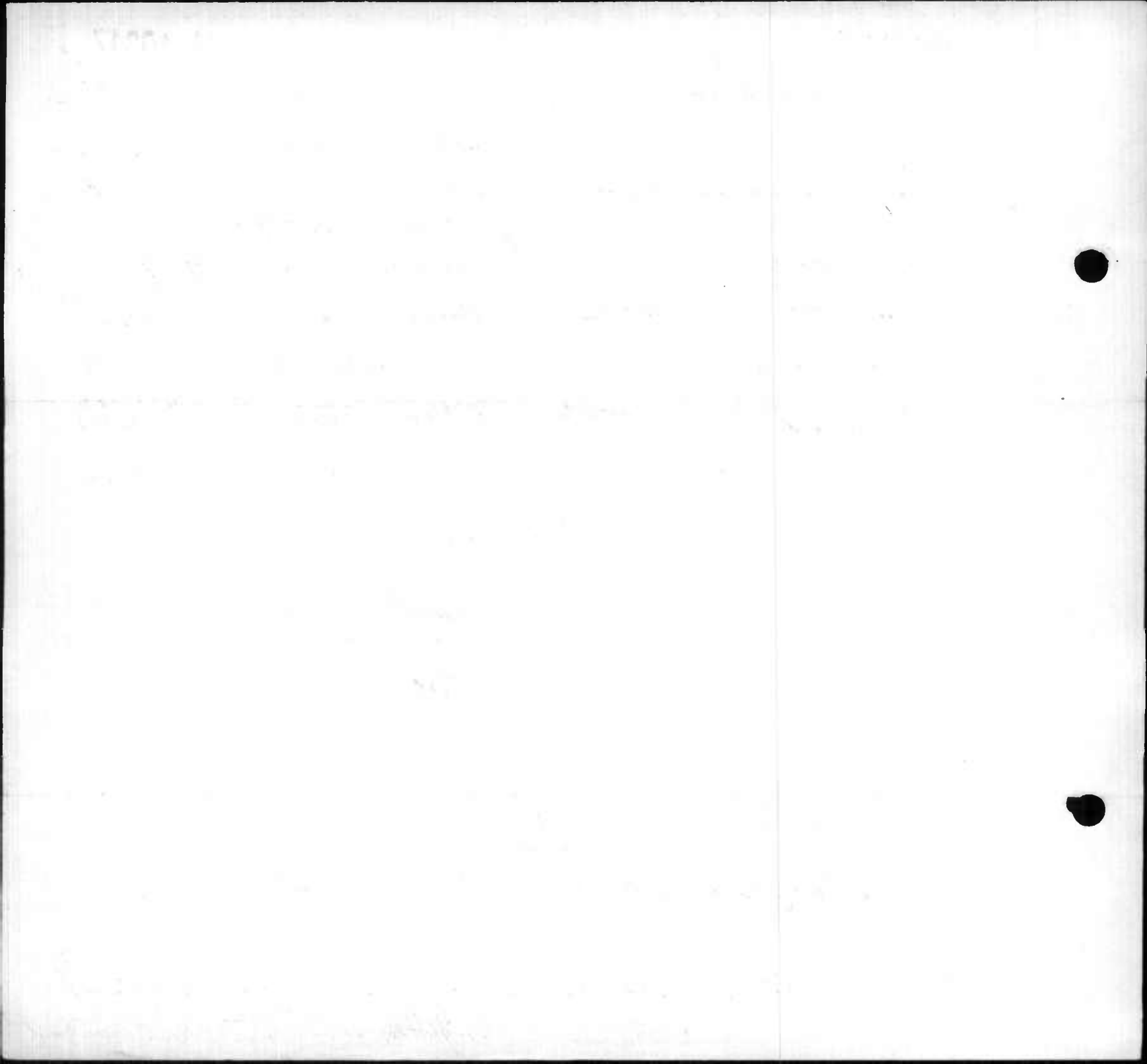
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                                                                                                                                                                                 |                                | 71 10346                                                                       |                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------|-------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                                                                                                                                                                                                 |                                | REG. NO. _____                                                                 |                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Mary Warthen</i>                                                                                                                                                                                                                                                                                            |                  | 2. DATE AND HOUR OF DEATH<br><i>11/7/71 1905 P.M.</i>                                                                                                                                                                                                                                                           |                                |                                                                                |                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>South Balto. Gen Hosp.</i><br><i>43</i>                                                                                                                                 |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>2403</i><br>C. CITY OR TOWN <i>Balto</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <i>1005 21st St.</i> |                                |                                                                                |                                           |
| 5. SEX <i>F</i>                                                                                                                                                                                                                                                                                                                                       | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                     | 8. DATE OF BIRTH <i>1/3/00</i> |                                                                                | 9. AGE (In years last birthday) <i>71</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>                                                                                                                                                                                                                                       |                  | 10B. KIND OF BUSINESS OR INDUSTRY _____                                                                                                                                                                                                                                                                         |                                | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore, Maryland</i>        |                                           |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                                                                                                                                                                                                                                            |                  | 13. FATHER'S NAME<br><i>Patrick Hanley</i>                                                                                                                                                                                                                                                                      |                                |                                                                                |                                           |
| 14. MOTHER'S MAIDEN NAME<br><i>Murphyers</i>                                                                                                                                                                                                                                                                                                          |                  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>                                                                                                                                                                                           |                                |                                                                                |                                           |
| 16. SOCIAL SECURITY NO.<br><i>15-16-5026 A</i>                                                                                                                                                                                                                                                                                                        |                  | 17. INFORMANT<br><i>Hosp. chart</i>                                                                                                                                                                                                                                                                             |                                |                                                                                |                                           |
| 18. CAUSE OF DEATH<br><i>183.01</i>                                                                                                                                                                                                                                                                                                                   |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                    |                                |                                                                                |                                           |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><i>Metastatic Ca</i>                                                                                                                                 |                  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                             |                                | <i>10 mos</i>                                                                  |                                           |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                        |                  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                             |                                | <i>1 yr</i>                                                                    |                                           |
| (C) <i>Dehydration</i>                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                                                                                                                                                                                 |                                |                                                                                |                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                |                  |                                                                                                                                                                                                                                                                                                                 |                                |                                                                                |                                           |
| 19A. DATE OF OPERATION _____                                                                                                                                                                                                                                                                                                                          |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____                                                                                                                                                                                                                                                          |                                | 20A. AUTOPSY? (Yes or No)<br><i>NO</i>                                         |                                           |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                                                                                                                                                                                                 |                                |                                                                                |                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                        |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____                                                                                                                                                                                                                  |                                | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ |                                           |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____                                                                                                                                                                                                                                                                                       |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                          |                                | 21F. HOW DID INJURY OCCUR? _____                                               |                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11/6</i> 19 <i>71</i> to <i>11/7</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>11/7</i> 19 <i>71</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |                                                                                                                                                                                                                                                                                                                 |                                |                                                                                |                                           |
| 23A. SIGNATURE<br><i>Stanford J. Huber MD</i>                                                                                                                                                                                                                                                                                                         |                  | 23B. DATE SIGNED<br><i>11/7/71</i>                                                                                                                                                                                                                                                                              |                                | 23C. PHYSICIAN'S NAME (Type)<br><i>Stanford J. Huber MD</i>                    |                                           |
| 23D. ADDRESS<br><i>3001 S. Hanover St</i>                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                                                                                                                                                                                 |                                |                                                                                |                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                             |                  | 24B. DATE<br><i>11-10-71</i>                                                                                                                                                                                                                                                                                    |                                | 24C. NAME of CEMETERY or CREMATORY<br><i>Cedar Hill Cemetery</i>               |                                           |
| 24D. LOCATION (City, town, or county)<br><i>Baltimore, Maryland</i>                                                                                                                                                                                                                                                                                   |                  | 24E. STATE<br><i>Md.</i>                                                                                                                                                                                                                                                                                        |                                |                                                                                |                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 9 1971</i>                                                                                                                                                                                                                                                                                                  |                  | 25B. NAME OF REGISTRAR<br><i>John R. ...</i>                                                                                                                                                                                                                                                                    |                                | 25C. FUNERAL DIRECTOR<br><i>McGuffey Funeral Home</i>                          |                                           |
| 25D. ADDRESS<br><i>130 East Fort Avenue Balto., Md. 21230</i>                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                                                                                                                                                                                 |                                |                                                                                |                                           |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                              |  | REG. NO. 71 10347                                                                                                  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO. 1105849                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                              |  | 10347                                                                                                              |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br>PAMELA M. WARFEL                                                                                                                                                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br>11/6/71 10:25 P.M.                                                                              |  |                                                                                                                    |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br>University of Maryland Hospital<br>38                                                                                                                                                                                                            |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md. B. COUNTY A.A.Co. 5200 |  | C. CITY OR TOWN HANOVER D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 5. SEX Female 6. RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                   |  | 8. DATE OF BIRTH 3-28-71 9. AGE (in years last birthday) 0                                                                   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                         |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                            |  | 10B. KIND OF BUSINESS OR INDUSTRY NONE                                                                                       |  | 11. BIRTHPLACE (State or foreign country) Maryland USA                                                             |  |
| 13. FATHER'S NAME William Warfel                                                                                                                                                                                                                                                                                                                       |  | 14. MOTHER'S MAIDEN NAME Elizabeth Zurek                                                                                     |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No                                                                                                                                                                                                                                            |  | 16. SOCIAL SECURITY NO. NONE                                                                                                 |  | 17. INFORMANT ADDRESS William Warfel - Rt. 2 Box - 146 HANOVER MD                                                  |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |                                                                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hrs.                                                               |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>Numerous operations and frequent intestinal obstructions                                                                                                                                                           |  |                                                                                                                              |  |                                                                                                                    |  |
| 19A. DATE OF OPERATION 0                                                                                                                                                                                                                                                                                                                               |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                             |  | 20A. AUTOPSY? (Yes or No) No                                                                                       |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                     |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                           |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                              |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                       |  | 21F. HOW DID INJURY OCCUR?                                                                                         |  |
| 22. I certify that (I) (this hospital) attended the deceased from 3/28/71 to 11/6/71 and that (I) (we) lost saw the deceased alive on 11/6/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                 |  |                                                                                                                              |  |                                                                                                                    |  |
| 23A. SIGNATURE H. Magabuech M.D.                                                                                                                                                                                                                                                                                                                       |  | 23B. DATE SIGNED 11/6/71                                                                                                     |  | 23C. PHYSICIAN'S NAME (Type)                                                                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                                        |  | 24B. DATE 11/9/71                                                                                                            |  | 24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery                                                             |  |
| 25A. DATE REC'D BY HEALTH DEPT. NOV 9 1971                                                                                                                                                                                                                                                                                                             |  | 25B. NAME OF REGISTRAR Robert E. Fisher, R.D.                                                                                |  | 25C. FUNERAL DIRECTOR R. P. R. Singleton Funeral Home / Glen Burnie, Md.                                           |  |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) Ethel G. Haines                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input checked="" type="checkbox"/> 11 6 71 1.40A M.                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF DECEASED IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION<br>2401 Gainesborough Ct. CV. 11-10-71                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>11 6 71 1.40A M.                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
| 6. SEX FEM.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 7. RACE Cau.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Md B. COUNTY 2737                                                                                                                                                                                                                                                                                                                                                                                                                            |  |
| 9. DATE OF BIRTH 7/24/1905                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10. AGE (In years lost birthday) 66                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |
| 11. BIRTHPLACE (State or foreign country) Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 14B. KIND OF BUSINESS OR INDUSTRY Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |
| 15. MOTHER'S MAIDEN NAME Edna Haines                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 13. FATHER'S NAME Walter Beach                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 17. SOCIAL SECURITY NO. 220-09-2196                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |
| 18. INFORMANT ADDRESS<br>6A Claude Haines - 2401 Gainesborough Ct                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic Cardiovascular Disease<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  |
| 20A. DATE OF OPERATION 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE: Werner U. Spitz, M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>EXAMINER'S NAME (Type) DATE SIGNED 11 6 71<br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 24B. DATE 11/9/71                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
| 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| 25A. DATE REC'D BY HEALTH DEPT. NOV 9 1971                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 25B. NAME OF REGISTRAR Robert C. Altenburg, R.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| 25C. FUNERAL DIRECTOR ADDRESS Robert C. Altenburg Funeral Home, Inc. 6009 Harford Rd. - Balto., Md. 21214                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |

letter from M. E. W. office  
11-10-71 M.H.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                               |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH                      |  |                                                                                                                                                      |  | REG. NO. 71 10349                                                                                                                                           |  |                                                                                                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------|--|--------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO. 71 10349                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                               |  |                                                              |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                                     |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Leonhard A. Hildebrandt</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                               |  |                                                              |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>11 5 71 8:30 a. M.</b> |  |                                                                                                                                                             |  |                                                                                                                                                     |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>37 Mercy Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                               |  |                                                              |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>11 5 71 8:30 a. M.</b>                                                                          |  |                                                                                                                                                             |  |                                                                                                                                                     |  |
| 6. SEX <b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                               |  |                                                              |  | 7. RACE <b>White</b>                                                                                                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> <b>5300</b> |  |
| 9. DATE OF BIRTH<br><b>Nov. 3, 1910</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10. AGE (In years last birthday)<br><b>61</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                      |  | 13. FATHER'S NAME<br><b>Robert Hildebrandt</b>                                                                                                              |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bakery</b>                                         |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 17. SOCIAL SECURITY NO.<br><b>213-10-1390</b> |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Schmidt Bakery</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Anna Ebersberger</b>                                                                                                  |  | 18. INFORMANT (Wife) <b>1736</b> ADDRESS <b>Langport Ave.</b><br><b>Mrs. Gladys J. Hildebrandt, Dundalk, Md.</b>                                            |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  |
| 19. <b>E81610</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Fracture of neck</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Arteriosclerotic cardiovascular disease</b>                                                                                                                                                                                                                                                                  |  |                                               |  |                                                              |  | CAUSE OF DEATH<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                       |  |                                                                                                                                                             |  |                                                                                                                                                     |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                               |  |                                                              |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>yes</b>                                                                                       |  |                                                                                                                                                             |  |                                                                                                                                                     |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                               |  |                                                              |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>STREET</b>                                            |  |                                                                                                                                                             |  |                                                                                                                                                     |  |
| 22D. TIME OF INJURY (APPROX.)<br>Month Day Year Hour<br><b>11 5 71 8:20 a. m.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                               |  |                                                              |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                 |  |                                                                                                                                                             |  |                                                                                                                                                     |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>Cathedral &amp; Franklin St. 401</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                               |  |                                                              |  | 22F. HOW DID INJURY OCCUR?<br><b>Subject driver of auto- lost control.</b>                                                                           |  |                                                                                                                                                             |  |                                                                                                                                                     |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>11/5/71</b><br>ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b><br>EXAMINER'S NAME (Type) |  |                                               |  |                                                              |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                                     |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                               |  | 24B. DATE<br><b>11/8/71</b>                                  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Oak Lawn Cemetery</b>                                                                                       |  |                                                                                                                                                             |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                                                                         |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 9 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                               |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, R.D.</b>      |  |                                                                                                                                                      |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>                                                                           |  |                                                                                                                                                     |  |



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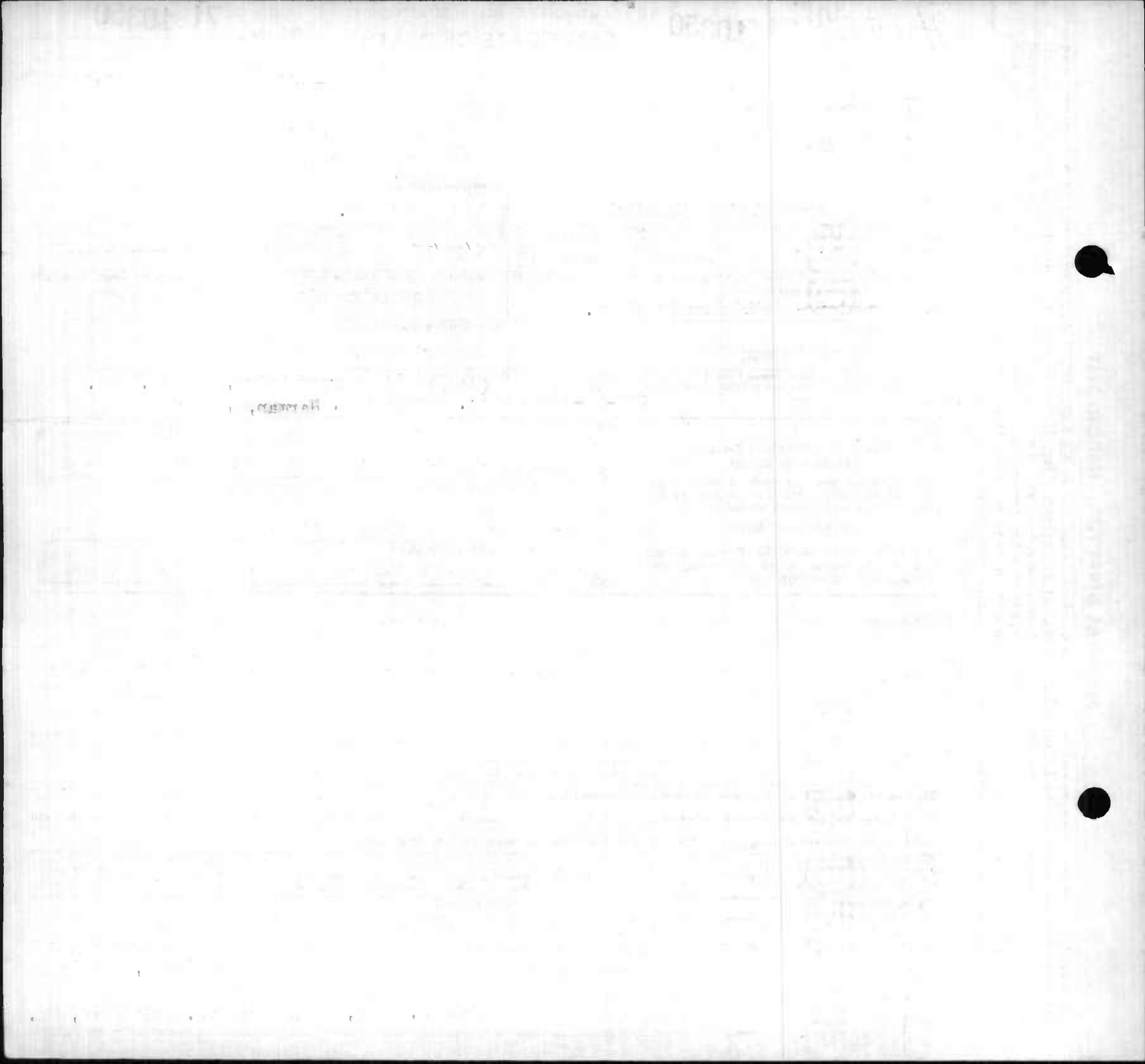
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

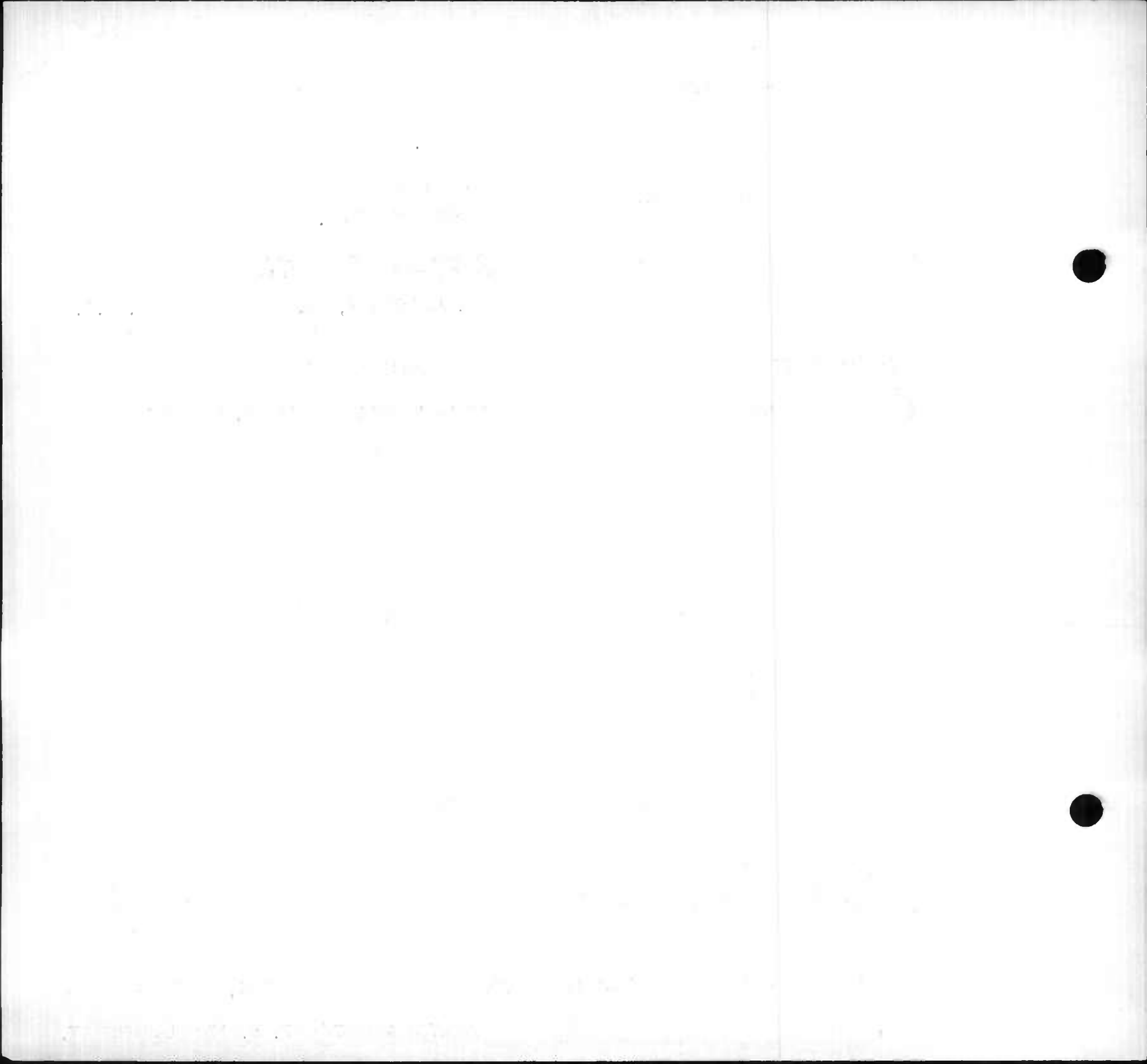
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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span>H-655 71 10350</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>                                                                                                                                                                                                                                                                                                       |                      | <div style="display: flex; justify-content: space-between;"> <span>REG. NO. 71 10350</span> </div>                                                                                                                                                                                                                              |                                 |
| BIRTH NO. <span style="float: right;">1</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                      |                                                                                                                                                                                                                                                                                                                                 |                                 |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Paul Harmon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | 2. DATE AND HOUR OF DEATH<br><b>11-5-71 12:36 P M.</b>                                                                                                                                                                                                                                                                          |                                 |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br><b>37 Mercy <del>CINNAM</del> Hospital</b>                                                                                                                                                                                                                                                                                     |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b><br><br>C. CITY OR TOWN <b>Middle River</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>15 Gunwood Dr.</b> |                                 |
| 5. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6. RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                | 8. DATE OF BIRTH <b>5/27/15</b> |
| 9. AGE (in years last birthday) <b>56</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | If Under 1 Yr. Months: Days: Hours: Min.                                                                                                                                                                                                                                                                                        | If Under 24 Hrs.                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Steel Erector - Bethlehem Steel Co.</b>                                                                                                                                                                                                                                                                                                                                                                     |                      | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>West Virginia</b>                                                                                                                                                                                                                                                                       |                                 |
| 11. BIRTHPLACE (State or foreign country)<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                      |                                 |
| 13. FATHER'S NAME<br><b>George Harmon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | 14. MOTHER'S MAIDEN NAME<br><b>Katherine Blankley</b>                                                                                                                                                                                                                                                                           |                                 |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes WWII</b>                                                                                                                                                                                                                                                                                                                                                                                   |                      | 16. SOCIAL SECURITY NO.<br><b>220-09-4950</b>                                                                                                                                                                                                                                                                                   |                                 |
| 17. INFORMANT (Wife) <b>15 Gunwood Drive, Balto. Md.</b><br><b>Mrs. Gertrude C. Harman, 21220</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                                                                                                                                                                                                 |                                 |
| 18. <b>4/10/91</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ACUTE MYOCARDIAL INFARCTION 2 days</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>EXTENSIVE</b><br><b>CORONARY ARTERY THROMBOSIS</b><br><b>ATHEROSCLEROTIC HEART DISEASE 15 YEARS</b> |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>                                                                                                                                                                                                                                                                   |                                 |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>NO YES</b>                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                                                                                                                                                                                                 |                                 |
| 19A. DATE OF OPERATION<br><b>NOV-2-1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>MESENTERIC THROMBOSIS</b>                                                                                                                                                                                                                                                |                                 |
| 20A. AUTOPSY (Yes or No)<br><b>YES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                      | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b>                                                                                                                                                                                                                                              |                                 |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                            |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><input type="checkbox"/>                                                                                                                                                                                                            |                                 |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                          |                      | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)<br><input type="checkbox"/>                                                                                                                                                                                                                                        |                                 |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                     |                      | 21F. HOW DID INJURY OCCUR?<br><input type="checkbox"/>                                                                                                                                                                                                                                                                          |                                 |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-31-1971</b> to <b>11-5-1971</b> that (I) (we) last saw the deceased alive on <b>11-5-1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                |                      |                                                                                                                                                                                                                                                                                                                                 |                                 |
| 23A. SIGNATURE<br><b>Joseph Notarangelo M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                      | 23B. DATE SIGNED<br><b>11-6-1971</b>                                                                                                                                                                                                                                                                                            |                                 |
| 23C. PHYSICIAN'S NAME (Type)<br><b>JOSEPH NOTARANGELO M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |                      | 23D. ADDRESS<br><b>MERCY HOSPITAL</b>                                                                                                                                                                                                                                                                                           |                                 |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | 24B. DATE<br><b>11/9/71</b>                                                                                                                                                                                                                                                                                                     |                                 |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |                      | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                     |                                 |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 9 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      | 25B. NAME OF REGISTRAR<br><b>Robert F. Talley, M.D.</b>                                                                                                                                                                                                                                                                         |                                 |
| 25C. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Baltimore, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      | ADDRESS                                                                                                                                                                                                                                                                                                                         |                                 |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

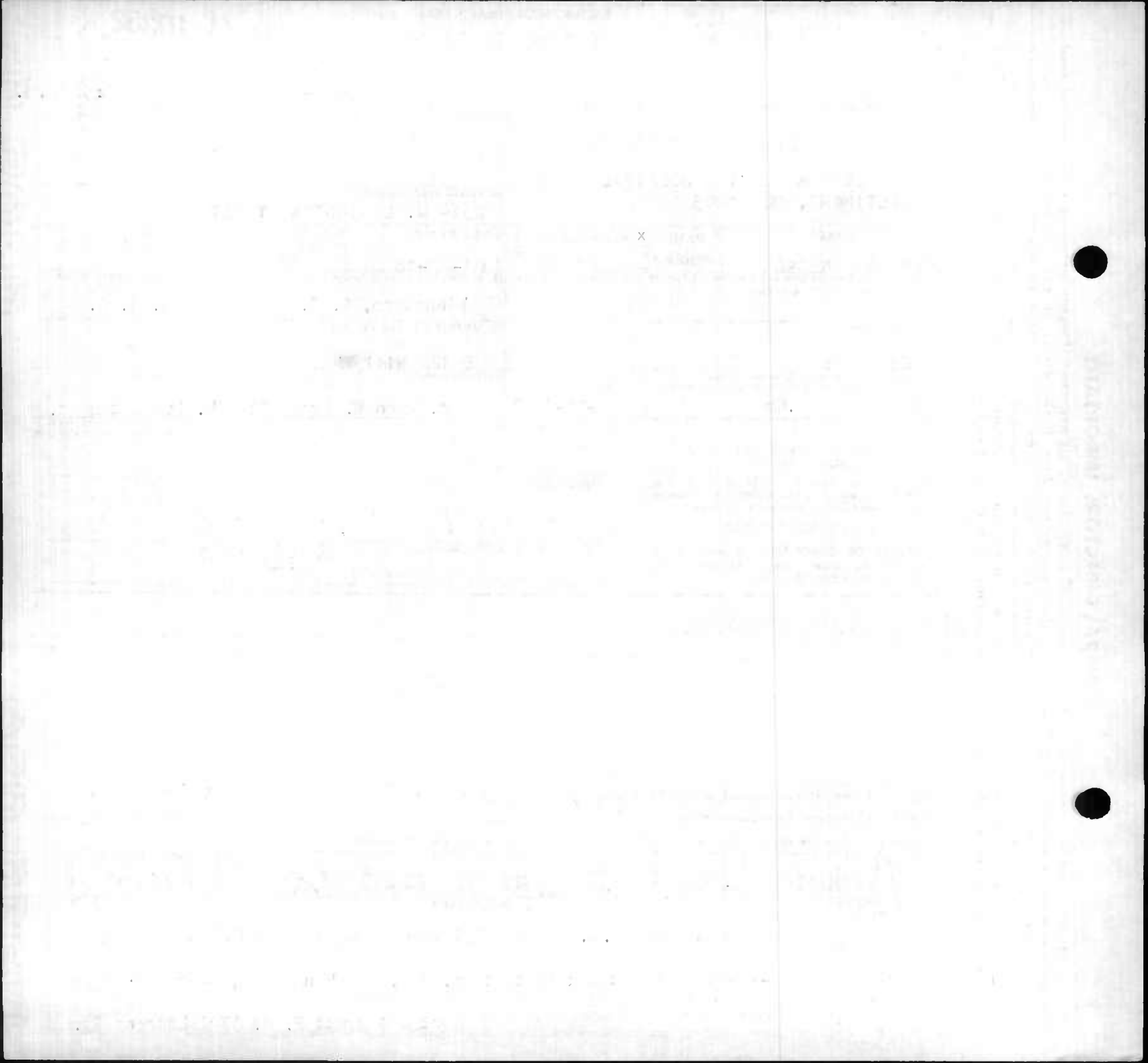
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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>                                                                                                                                                                              |                  | 71 10351<br>REG. NO.                                                                                                                                                                                                                                                                                                                  |                                           |
| BIRTH NO. <u>W-562</u> <u>71 10351</u>                                                                                                                                                                                                       |                  | 2. DATE AND HOUR OF DEATH<br><u>11-6-71</u> <u>3:41 A.M.</u>                                                                                                                                                                                                                                                                          |                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Alberta Waters</u>                                                                                                                                                                                 |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <u>MD.</u><br>B. COUNTY <u>1502</u>                                                                                                                                                                                                  |                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>39 PROVIDENT HOSPITAL</u>                                      |                  | C. CITY OR TOWN <u>BALTIMORE</u><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>1622 BRUCE CT.</u>                                                                                                                                                          |                                           |
| 5. SEX <u>F</u>                                                                                                                                                                                                                              | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                           | 8. DATE OF BIRTH <u>3-29-1895</u>         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                  |                  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                     | 9. AGE (In years last birthday) <u>76</u> |
| 13. FATHER'S NAME<br><u>THOMAS GANTT</u>                                                                                                                                                                                                     |                  | 14. MOTHER'S MAIDEN NAME<br><u>MAGGIE GANTT</u>                                                                                                                                                                                                                                                                                       |                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u> <u>No</u>                                                                                                              |                  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                               |                                           |
| 17. INFORMANT<br><u>LEOLA WOMACK</u>                                                                                                                                                                                                         |                  | ADDRESS<br><u>319 S. VINCENT</u>                                                                                                                                                                                                                                                                                                      |                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><u>Metastatic Adenocarcinoma Bladder</u> |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 months</u>                                                                                                                                                                                                                                                                       |                                           |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                               |                  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>ASCVD - CHF. med. hypercholesterolemia also?</u>                                                                                                                                                                                                                            |                                           |
| (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                          |                  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                   |                                           |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                             |                  | 19A. DATE OF OPERATION <u>7-1-71</u>                                                                                                                                                                                                                                                                                                  |                                           |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>remission</u>                                                                                                                                                                         |                  | 20A. AUTOPSY? (Yes or No) <u>no</u>                                                                                                                                                                                                                                                                                                   |                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                               |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                              |                                           |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                    |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                             |                                           |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                   |                  | 22. I certify that (this hospital) attended the deceased from <u>6/24</u> 19 <u>71</u> to <u>7-9</u> 19 <u>71</u><br>that (we) last saw the deceased alive on <u>Sept</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did not) view the body after death. |                                           |
| 23A. SIGNATURE<br><u>[Signature]</u>                                                                                                                                                                                                         |                  | 23B. DATE SIGNED<br><u>11/8/71</u>                                                                                                                                                                                                                                                                                                    |                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><u>[Signature]</u>                                                                                                                                                                                           |                  | 23D. ADDRESS<br><u>[Address]</u>                                                                                                                                                                                                                                                                                                      |                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                    |                  | 24B. DATE<br><u>11-9-71</u>                                                                                                                                                                                                                                                                                                           |                                           |
| 24C. NAME OF CEMETERY or CREMATORY<br><u>MT AUBURN CEMETERY</u>                                                                                                                                                                              |                  | 24D. LOCATION (City, town, or county) (State)<br><u>BALTIMORE, MARYLAND</u>                                                                                                                                                                                                                                                           |                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 9 1971</u>                                                                                                                                                                                         |                  | 25B. NAME OF REGISTRAR<br><u>Robert E. Bailey, M.D.</u>                                                                                                                                                                                                                                                                               |                                           |
| 25C. FUNERAL DIRECTOR<br><u>MORTON &amp; DYTT</u>                                                                                                                                                                                            |                  | ADDRESS<br><u>F. H. 1701 LAURENS ST.</u>                                                                                                                                                                                                                                                                                              |                                           |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-630 71 10352                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                           |  | REG. NO. 71 10352                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | CERTIFICATE OF DEATH                                                                                                                       |  |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>ELIZA BYRD</b>                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | 2. DATE AND HOUR OF DEATH<br><b>11-06-71 3:50 A.M.</b>                                                                                     |  |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2002</b> |  |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>THE JOHNS HOPKINS HOSPITAL</b><br><b>BALTIMORE, MD 21205</b>                                                                                                                                                                                                                                |  |                                                                                                        |  | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                        |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX <b>FEMALE</b> 6. RACE <b>NEGRO</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                     |  |                                                                                                        |  | 8. DATE OF BIRTH<br><b>03-22-18</b> 9. AGE (In years last birthday) <b>53</b>                                                              |  | 10. AGE (If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.)                           |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                            |  |                                                                                                        |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                          |  | 11. BIRTHPLACE (State or foreign country)<br><b>Winnsboro, S. C.</b>                          |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | 13. FATHER'S NAME<br><b>ED GLOVER</b>                                                                                                      |  |                                                                                               |  |
| 14. MOTHER'S MAIDEN NAME<br><b>ELIZA Hill</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No <b>No</b>                   |  |                                                                                               |  |
| 16. SOCIAL SECURITY NO.<br><b>217-22-6357</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  | 17. INFORMANT<br><b>Mr. John B. Byrd 2314 W. Lexington St.</b>                                                                             |  |                                                                                               |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>182.01 Anemia, Dehydration, Cachexia</b>                                                                                                                                                                                                                                      |  |                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5/70 → 11/6/71</b>                                                                      |  |                                                                                               |  |
| (This does not mean the mode of dying, e.g., heart failure, athermia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                           |  |                                                                                                        |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Recurrent Undifferentiated</b>                                                   |  |                                                                                               |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                         |  |                                                                                                        |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Adenocarcinoma endometrium</b>                                                                   |  |                                                                                               |  |
| (C)                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                            |  |                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                            |  |                                                                                               |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                 |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                                                                     |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                   |  |                                                                                               |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                              |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                                 |  |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11/5/71</b> 19__ to <b>11/6/71</b> 19__ that (I) (we) last saw the deceased alive on <b>11/6/71</b> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                            |  |                                                                                               |  |
| 23A. SIGNATURE<br><b>Norman D. Koku M.D.</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | 23B. DATE SIGNED<br><b>11/6/71</b>                                                                                                         |  | 23C. PHYSICIAN'S NAME (Type)<br><b>NORMAN DAIKOKU M.D.</b>                                    |  |
| 23D. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                            |  |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                              |  | 24B. DATE<br><b>11-13-71</b>                                                                           |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Blackjack Baptist Ch. Cem.</b>                                                                    |  | 24D. LOCATION (City, town, or county) (State)<br><b>Winnsboro, South Carolina</b>             |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 9 1971</b>                                                                                                                                                                                                                                                                                   |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>                                                |  | 25C. FUNERAL DIRECTOR<br><b>Morton &amp; Dyett F. H. 1701 Laurens St.</b>                                                                  |  |                                                                                               |  |



## CERTIFICATE OF DEATH

REG. NO. 71 10353

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                          |                      |                                                                                                                                                                                                                                                                                                                             |                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| BIRTH NO. 71 10353                                                                                                                                                                                                                                                                                                                                       |                      | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                            |                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Garland Bratcher</u>                                                                                                                                                                                                                                                                                           |                      | 2. DATE AND HOUR OF DEATH<br><u>11-6-71</u> <u>2:40 P.M.</u>                                                                                                                                                                                                                                                                |                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>BALTIMORE CITY HOSPITALS</u><br><u>4940 Eastern Avenue</u><br><u>Baltimore, Maryland 21224</u>                                                                             |                      | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MD</u> B. COUNTY <u>BALTO</u><br>C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <u>122 WILLOW CT</u> <u>21222</u> |                                           |
| 5. SEX <u>Male</u>                                                                                                                                                                                                                                                                                                                                       | 6. RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                 | 8. DATE OF BIRTH <u>12/25/12</u>          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                              |                      | 10B. KIND OF BUSINESS OR INDUSTRY <u>Beth Steel</u>                                                                                                                                                                                                                                                                         | 9. AGE (in years last birthday) <u>58</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Durham, N.C.</u>                                                                                                                                                                                                                                                                                            |                      | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                                                                                                                                                                                                                                                                  |                                           |
| 13. FATHER'S NAME <u>UNKNOWN</u>                                                                                                                                                                                                                                                                                                                         |                      | 14. MOTHER'S MAIDEN NAME <u>Henrietta</u>                                                                                                                                                                                                                                                                                   |                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>                                                                                                                                                                                                                                    |                      | 16. SOCIAL SECURITY NO. <u>243-07-5168</u>                                                                                                                                                                                                                                                                                  |                                           |
| 17. INFORMANT <u>BCH RECORDS:</u>                                                                                                                                                                                                                                                                                                                        |                      | ADDRESS <u>4940 Eastern Avenue</u><br><u>Baltimore, Maryland 21224</u>                                                                                                                                                                                                                                                      |                                           |
| 18. <u>1619 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                      | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <u>CARCINOMA LARYNX -</u> <u>1 YEAR</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____                                                                                                                                       |                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                   |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                |                                           |
| 19A. DATE OF OPERATION <u>11-9-71</u>                                                                                                                                                                                                                                                                                                                    |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                            |                                           |
| 20A. AUTOPSY? (Yes or No) <u>NO</u>                                                                                                                                                                                                                                                                                                                      |                      | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                        |                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                    |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                    |                                           |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                 |                      | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                   |                                           |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                |                      | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                  |                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept 7</u> 19 <u>71</u> to <u>Nov 6</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11/6</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                      |                                                                                                                                                                                                                                                                                                                             |                                           |
| 23A. SIGNATURE <u>Paul G. Whipple M.D.</u>                                                                                                                                                                                                                                                                                                               |                      | 23B. DATE SIGNED <u>11-6-71</u>                                                                                                                                                                                                                                                                                             |                                           |
| 23C. PHYSICIAN'S NAME (Type) <u>Paul G. Whipple M.D.</u>                                                                                                                                                                                                                                                                                                 |                      | 23D. ADDRESS <u>BALTIMORE CITY HOSPITALS</u>                                                                                                                                                                                                                                                                                |                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>                                                                                                                                                                                                                                                                                                   |                      | 24B. DATE <u>11-9-71</u>                                                                                                                                                                                                                                                                                                    |                                           |
| 24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Pk.</u>                                                                                                                                                                                                                                                                                               |                      | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>                                                                                                                                                                                                                                                         |                                           |
| 25A. DATE REC'D BY HEALTH DEPT. <u>NOV 9 1971</u>                                                                                                                                                                                                                                                                                                        |                      | 25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>                                                                                                                                                                                                                                                                         |                                           |
| 25C. FUNERAL DIRECTOR <u>Morton H. Dyett</u>                                                                                                                                                                                                                                                                                                             |                      | ADDRESS <u>St. 1701 - Lawrence's</u>                                                                                                                                                                                                                                                                                        |                                           |

Post-Office  
Dunham, N.Y.  
Haverhill

Post-Office  
Haverhill

NO. 1000

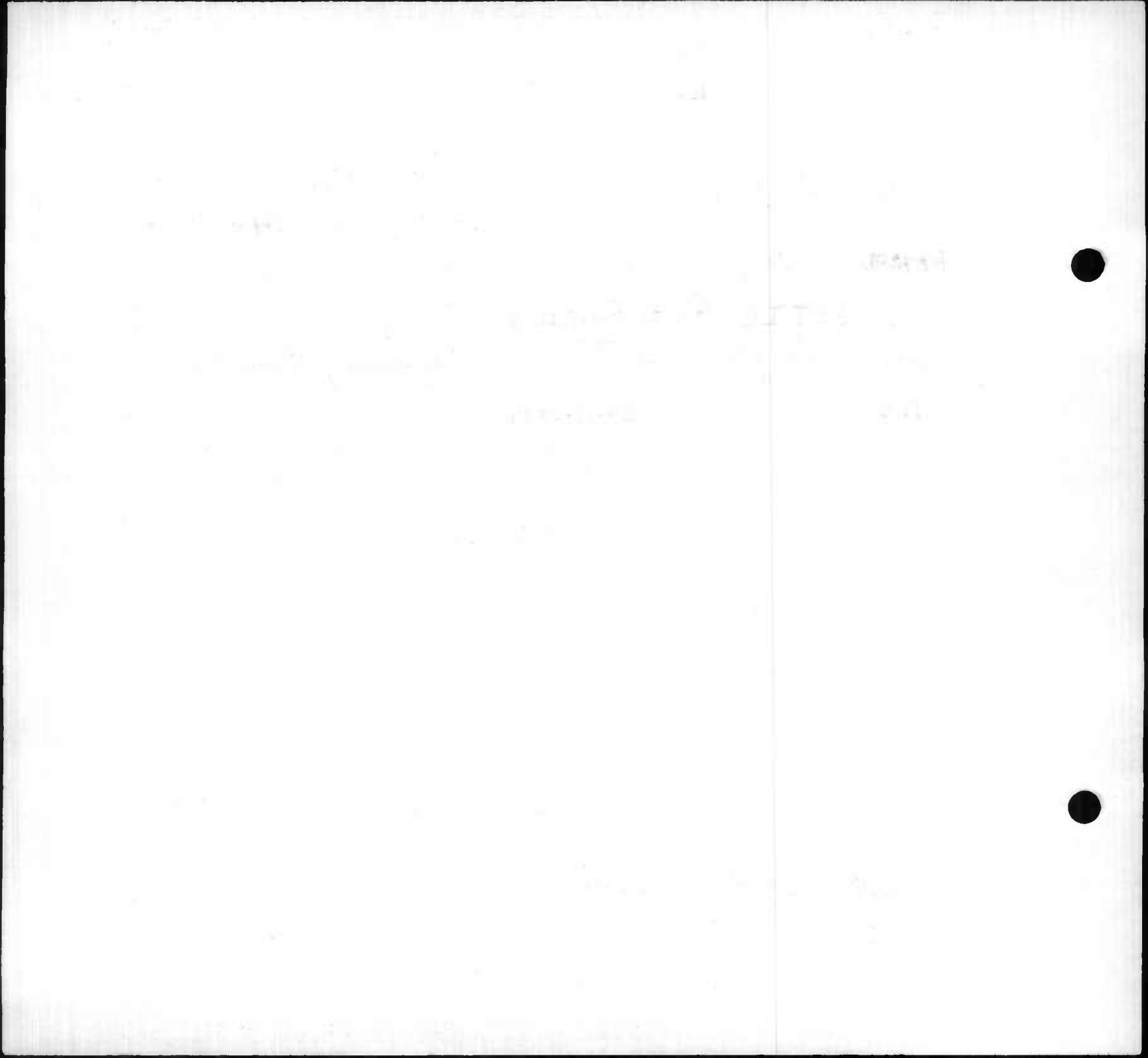
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Post-Office  
Dunham, N.Y.  
Haverhill



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>R-330</b>      <b>71 10354</b></p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p><b>CERTIFICATE OF DEATH</b></p>                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                 | <p>REG. NO. <b>71 10354</b></p>                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                               |
| <p>BIRTH NO. <b>71 10354</b></p> <p>1. NAME OF DECEASED (Type or Print) <b>ELLA L. RIDEOUT</b></p>                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                 | <p>2. DATE AND HOUR OF DEATH <b>11-8-71 7:02 A.M.</b></p>                                                                                                                                                                                                                                                                            |                                                                                                                                                                               |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BON SECOURS</b></p>                                                                                                                                                                                                                                               |                                                                                                                                                                 | <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <b>MD</b> B. COUNTY <b>1303</b></p> <p>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>2506 McCULLOH St.</b></p> |                                                                                                                                                                               |
| <p>5. SEX <b>FEMALE</b></p> <p>6. RACE <b>BLACK</b></p>                                                                                                                                                                                                                                                                                                                                                                                         | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> | <p>8. DATE OF BIRTH <b>04-01-03</b></p> <p>9. AGE (In years last birthday) <b>68</b></p>                                                                                                                                                                                                                                             | <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b></p> <p>11. BIRTHPLACE (State or foreign country) <b>MD.</b></p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b></p> <p>10B. KIND OF BUSINESS OR INDUSTRY <b>PUZ. FAMILY</b></p>                                                                                                                                                                                                                                                                  |                                                                                                                                                                 | <p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b></p>                                                                                                                                                                                                                                                                                      |                                                                                                                                                                               |
| <p>13. FATHER'S NAME <b>James Taylor Scott</b></p>                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                 | <p>14. MOTHER'S MAIDEN NAME <b>Thomas, Louise</b></p>                                                                                                                                                                                                                                                                                |                                                                                                                                                                               |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b></p>                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                 | <p>16. SOCIAL SECURITY NO. <b>214-22-2539</b></p>                                                                                                                                                                                                                                                                                    | <p>17. INFORMANT ADDRESS <b>Asbury C. Rideout 2506 McCulloh St.</b></p>                                                                                                       |
| <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH <b>CARDIAC ARREST PROBABLE DUE TO ACUTE CORONARY OCCLUSION</b></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <b>?</b></p> <p>(C) _____</p> |                                                                                                                                                                 | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b></p>                                                                                                                                                                                                                                                                   |                                                                                                                                                                               |
| <p>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                               |
| <p>19A. DATE OF OPERATION <b>0</b></p>                                                                                                                                                                                                                                                                                                                                                                                                          | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>                                                                                                         | <p>20A. AUTOPSY? (Yes or No)</p>                                                                                                                                                                                                                                                                                                     | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>                                                                                                   |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                           | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>                                                                  | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>                                                                                                                                                                                                                                                      |                                                                                                                                                                               |
| <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>                                                                                                                                                                                                                                                                                                                                                                                | <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>                                                   | <p>21F. HOW DID INJURY OCCUR?</p>                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                               |
| <p>22. I certify that (I) (this hospital) attended the deceased from <b>11-7-71</b> to <b>11-8-71</b> and that (I) (we) lost saw the deceased alive on <b>11-7-71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>                                                                                                              |                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                               |
| <p>23A. SIGNATURE <b>Oscar E. Fernandini</b></p>                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                 | <p>23B. DATE SIGNED <b>11-8-71</b></p>                                                                                                                                                                                                                                                                                               | <p>23C. PHYSICIAN'S NAME (Type) <b>OSCAR E. FERNANDINI</b></p>                                                                                                                |
| <p>24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                 | <p>24B. DATE <b>11-11-71</b></p>                                                                                                                                                                                                                                                                                                     | <p>24C. NAME OF CEMETERY OR CREMATORY <b>Maryland National Cem. Carver Memorial Park</b></p>                                                                                  |
| <p>24D. LOCATION <b>Laurel</b></p>                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                 | <p>24E. (City, town, or county) <b>Maryland</b></p>                                                                                                                                                                                                                                                                                  |                                                                                                                                                                               |
| <p>25A. DATE REC'D BY HEALTH DEPT. <b>NOV 9 1971</b></p>                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                 | <p>25B. NAME OF REGISTRAR <b>Robert E. Taylor</b></p>                                                                                                                                                                                                                                                                                | <p>25C. FUNERAL DIRECTOR ADDRESS <b>NUTTER FUNERAL HOME 3035 W. NORTH AVE.</b></p>                                                                                            |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                  | REG. NO. <b>71 10355</b>                     |                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| C-620 71 10355                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                  | CERTIFICATE OF DEATH                         |                                                                                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <b>CROSS, DAVID JAMES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>11/06/71 9:40AM</b>                                                                                                                                                                                                                                                                              |                                              |                                                                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>ST AGNES HOSPITAL</b><br><b>40</b>                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>HOWARD</b><br>C. CITY OR TOWN <b>ELLICOTT CITY</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>3680 Mt. Olive Drive</b> |                                              |                                                                                                           |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6. RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>02/16/29</b>                                                                                                                                                                                                                                                                                              | 9. AGE (In years last birthday)<br><b>42</b> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cook</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cook</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b>                                                                                                                                                                                                                                                                           |                                              | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                              |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             | 13. FATHER'S NAME<br><b>AMBROSS CROSS</b>                                                                                                                                                                                                                                                                                        |                                              |                                                                                                           |
| 14. MOTHER'S MAIDEN NAME<br><b>ELIZABETH BLACKWELL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                            |                                              |                                                                                                           |
| 16. SOCIAL SECURITY NO.<br><b>213 26 4214</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             | 17. INFORMANT<br><b>Edward Blackwell</b>                                                                                                                                                                                                                                                                                         |                                              |                                                                                                           |
| 18. CAUSE OF DEATH<br><b>199.01</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Antecedent Causes</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>2</b> |                         |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>weeks</b><br><b>years</b>                                                                                                                                                                                                                                                     |                                              |                                                                                                           |
| 19A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                 |                                              |                                                                                                           |
| 20A. AUTOPSY? (Yes or No)<br><b>YES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                             |                                              |                                                                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                         |                                              |                                                                                                           |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                        |                                              |                                                                                                           |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                       |                                              |                                                                                                           |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/03/71</b> 19 to <b>11/06/71</b> 19<br>that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/06/71</b> 19 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.                                                |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                  |                                              |                                                                                                           |
| 23A. SIGNATURE<br><b>Charles R. Chaney</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             | 23B. DATE SIGNED<br><b>11/7/71</b>                                                                                                                                                                                                                                                                                               |                                              |                                                                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>CHARLES R. CHANEY M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             | 23D. ADDRESS<br><b>CATON &amp; WILKENS AVES. BALTO. MD. 21229</b>                                                                                                                                                                                                                                                                |                                              |                                                                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             | 24B. DATE<br><b>11-10-71</b>                                                                                                                                                                                                                                                                                                     |                                              |                                                                                                           |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Western Star Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             | 24D. LOCATION<br><b>Baltimore Co. Maryland</b>                                                                                                                                                                                                                                                                                   |                                              |                                                                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 9 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             | 25B. NAME OF REGISTRAR<br><b>Robert E. Farley M.D.</b>                                                                                                                                                                                                                                                                           |                                              |                                                                                                           |
| 25C. FUNERAL DIRECTOR<br><b>NUTTER FUNERAL HOME</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 25D. ADDRESS<br><b>3035 W. NORTH AVE</b>                                                                                                                                                                                                                                                                                         |                                              |                                                                                                           |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                           |         |                                                                                                                                                          |                                                                                       | REG. NO. 71 10356                                                        |                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------------------------|
| P-160 71 10356                                                                                                                                                                                                                                                                                             |         |                                                                                                                                                          |                                                                                       | 71 10356                                                                 |                                                                     |
| BIRTH NO.                                                                                                                                                                                                                                                                                                  |         | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                   |                                                                                       | 2. DATE AND HOUR OF DEATH                                                |                                                                     |
|                                                                                                                                                                                                                                                                                                            |         | Katherine M. Pfeffer                                                                                                                                     |                                                                                       | November 8, 1971 M.                                                      |                                                                     |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                     |         |                                                                                                                                                          | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |                                                                          |                                                                     |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                  |         |                                                                                                                                                          | A. STATE B. COUNTY                                                                    |                                                                          |                                                                     |
| 40 St. Agnes Hospital                                                                                                                                                                                                                                                                                      |         |                                                                                                                                                          | Maryland                                                                              |                                                                          |                                                                     |
|                                                                                                                                                                                                                                                                                                            |         |                                                                                                                                                          | C. CITY OR TOWN                                                                       |                                                                          | D. INSIDE CITY LIMITS?                                              |
|                                                                                                                                                                                                                                                                                                            |         |                                                                                                                                                          | Baltimore                                                                             |                                                                          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                            |         |                                                                                                                                                          | E. STREET AND NUMBER                                                                  |                                                                          |                                                                     |
|                                                                                                                                                                                                                                                                                                            |         |                                                                                                                                                          | 22 S. Athol Avenue                                                                    |                                                                          |                                                                     |
| 5. SEX                                                                                                                                                                                                                                                                                                     | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH                                                                      | 9. AGE (In years last birthday)                                          | 10. Under 1 Yr. Months Days                                         |
| Female                                                                                                                                                                                                                                                                                                     | White   |                                                                                                                                                          | 6/25/1875                                                                             | 96                                                                       |                                                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                |         |                                                                                                                                                          | 11. BIRTHPLACE (State or foreign country)                                             |                                                                          | 12. CITIZEN OF WHAT COUNTRY?                                        |
|                                                                                                                                                                                                                                                                                                            |         |                                                                                                                                                          | Maryland                                                                              |                                                                          |                                                                     |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                          |         |                                                                                                                                                          | 14. MOTHER'S MAIDEN NAME                                                              |                                                                          |                                                                     |
| Frederick Pfeffer                                                                                                                                                                                                                                                                                          |         |                                                                                                                                                          | Katherine Dannenfelson                                                                |                                                                          |                                                                     |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                   |         | 16. SOCIAL SECURITY NO.                                                                                                                                  | 17. INFORMANT ADDRESS                                                                 |                                                                          |                                                                     |
|                                                                                                                                                                                                                                                                                                            |         | 217-54-2297-J                                                                                                                                            | General German Aged Home 22 S. Athol Ave.                                             |                                                                          |                                                                     |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                         |         |                                                                                                                                                          | CAUSE OF DEATH                                                                        |                                                                          |                                                                     |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                |         |                                                                                                                                                          | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |                                                                          |                                                                     |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                          |         |                                                                                                                                                          | Cardiac Arrhythmia                                                                    |                                                                          |                                                                     |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                  |         |                                                                                                                                                          | (B) Arteriosclerotic Heart Disease                                                    |                                                                          |                                                                     |
|                                                                                                                                                                                                                                                                                                            |         |                                                                                                                                                          | (C) Cardiac failure                                                                   |                                                                          |                                                                     |
| II                                                                                                                                                                                                                                                                                                         |         |                                                                                                                                                          |                                                                                       |                                                                          |                                                                     |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                           |         |                                                                                                                                                          |                                                                                       |                                                                          |                                                                     |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                     |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                                       | 20A. AUTOPSY? (Yes or No)                                                |                                                                     |
|                                                                                                                                                                                                                                                                                                            |         |                                                                                                                                                          |                                                                                       | NO                                                                       |                                                                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                      |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                 |                                                                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                     |
|                                                                                                                                                                                                                                                                                                            |         |                                                                                                                                                          |                                                                                       |                                                                          |                                                                     |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                  |         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                       | 21F. HOW DID INJURY OCCUR?                                               |                                                                     |
|                                                                                                                                                                                                                                                                                                            |         |                                                                                                                                                          |                                                                                       |                                                                          |                                                                     |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 1971 to 8 Nov 1971, that (I) (we) last saw the deceased alive on 8 Nov 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |                                                                                                                                                          |                                                                                       |                                                                          |                                                                     |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                             |         |                                                                                                                                                          |                                                                                       | 23B. DATE SIGNED                                                         |                                                                     |
| William J. Bryson M.D.                                                                                                                                                                                                                                                                                     |         |                                                                                                                                                          |                                                                                       | 8 Nov 71                                                                 |                                                                     |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                               |         |                                                                                                                                                          |                                                                                       | 23D. ADDRESS                                                             |                                                                     |
| Wm. J. Bryson                                                                                                                                                                                                                                                                                              |         |                                                                                                                                                          |                                                                                       | Westview Mall                                                            |                                                                     |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                   |         | 24B. DATE                                                                                                                                                |                                                                                       | 24C. NAME OF CEMETERY or CREMATORY                                       |                                                                     |
| Burial                                                                                                                                                                                                                                                                                                     |         | 11/10/71                                                                                                                                                 |                                                                                       | Baltimore Cemetery                                                       |                                                                     |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                            |         | 25B. NAME OF REGISTRAR                                                                                                                                   |                                                                                       | 25C. FUNERAL DIRECTOR ADDRESS                                            |                                                                     |
| NOV 10 1971                                                                                                                                                                                                                                                                                                |         | Robert E. Fisher, R.D.                                                                                                                                   |                                                                                       | Witzke, 1630 Edmondson Avenue 21228                                      |                                                                     |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                      |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <div style="display: flex; justify-content: space-between;"> <span>S-361 71 10357</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>                                                                                                                                                     |  | REG. NO. <b>71 10357</b>                                                                                                                                                                                                                                             |  |
| BIRTH NO. _____                                                                                                                                                                                                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br>November 8, 1971 M.                                                                                                                                                                                                                     |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Bessye L. Strobel</b>                                                                                                                                                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2864</b>                                                                                                                           |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>90 General German Aged Home</b><br><b>22 So. Athol Avenue</b>                                                                                                                 |  | C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                       |  |
| 5. SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                        |  | 6. RACE <b>White</b>                                                                                                                                                                                                                                                 |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                 |  | 8. DATE OF BIRTH <b>12/3/1882</b>                                                                                                                                                                                                                                    |  |
| 9. AGE (In years last birthday) <b>88</b>                                                                                                                                                                                                                                                                                                                   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____                                                                                                                                                                     |  |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>                                                                                                                                                                                                                                                                                                   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                                                                                                                                              |  |
| 13. FATHER'S NAME <b>Walter J. Rhodes</b>                                                                                                                                                                                                                                                                                                                   |  | 14. MOTHER'S MAIDEN NAME <b>Sadie P.</b>                                                                                                                                                                                                                             |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____                                                                                                                                                                                                                                              |  | 16. SOCIAL SECURITY NO. <b>212-09-9383A</b>                                                                                                                                                                                                                          |  |
| 17. INFORMANT <b>General German Aged Home</b>                                                                                                                                                                                                                                                                                                               |  | ADDRESS <b>22 S. Athol Avenue</b>                                                                                                                                                                                                                                    |  |
| 18. <b>412.3 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Vascular Accident</b><br>(B) <b>Advanced arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>Arteriosclerotic Heart Disease</b><br><br><b>Asricular Fibrillation</b> |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____                                                                                                                                                                                                                   |  |
| 19A. DATE OF OPERATION <b>0</b>                                                                                                                                                                                                                                                                                                                             |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____                                                                                                                                                                                                               |  |
| 20A. AUTOPSY? (Yes or No) <b>No</b>                                                                                                                                                                                                                                                                                                                         |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____                                                                                                                                                                                           |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                              |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____                                                                                                                                                                       |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____                                                                                                                                                                                                                                                                              |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____                                                                                                                                                                                                      |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                      |  | 21F. HOW DID INJURY OCCUR? _____                                                                                                                                                                                                                                     |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>June</b> 19 <b>71</b> to <b>8 Nov.</b> 19 <b>71</b> , that (I) (we) last saw the deceased alive on <b>8 Nov.</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                                                                                                                                                      |  |
| 23A. SIGNATURE <b>William J. Bryson MD</b>                                                                                                                                                                                                                                                                                                                  |  | 23B. DATE SIGNED <b>9 Nov 71</b>                                                                                                                                                                                                                                     |  |
| 23C. PHYSICIAN'S NAME (Type) <b>Wm. J. Bryson</b>                                                                                                                                                                                                                                                                                                           |  | 23D. ADDRESS <b>Westview Mall</b>                                                                                                                                                                                                                                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                      |  | 24B. DATE <b>11/10/71</b>                                                                                                                                                                                                                                            |  |
| 24C. NAME OF CEMETERY or CREMATORY <b>Parkwood</b>                                                                                                                                                                                                                                                                                                          |  | 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>                                                                                                                                                                                             |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 10 1971</b>                                                                                                                                                                                                                                                                                                          |  | 25B. NAME OF REGISTRAR <b>Robert E. Tabor, M.D.</b>                                                                                                                                                                                                                  |  |
| 25C. FUNERAL DIRECTOR <b>Witzke, 1630 Edmondson Avenue</b>                                                                                                                                                                                                                                                                                                  |  | ADDRESS <b>21228</b>                                                                                                                                                                                                                                                 |  |

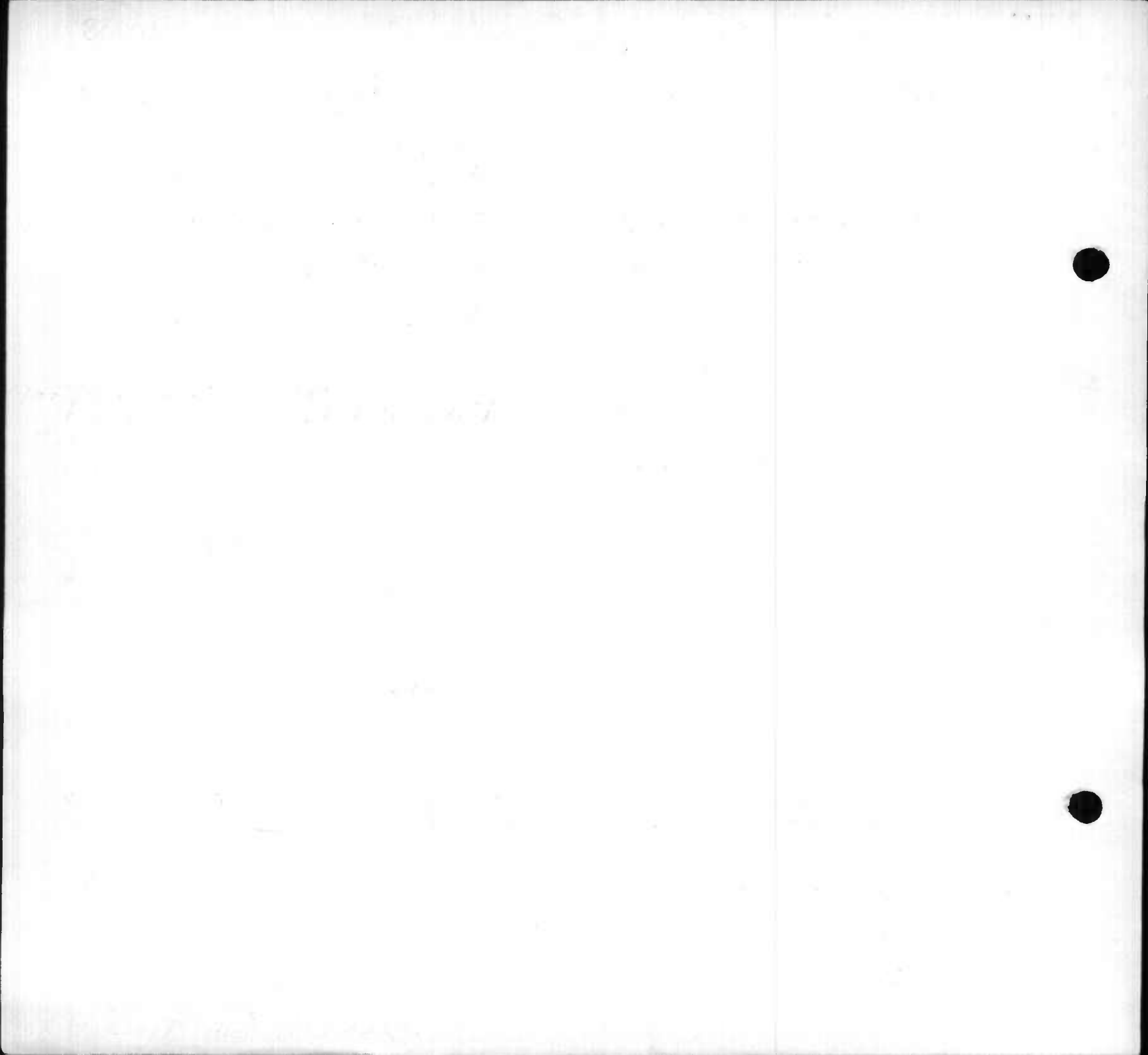
1963-Adm.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

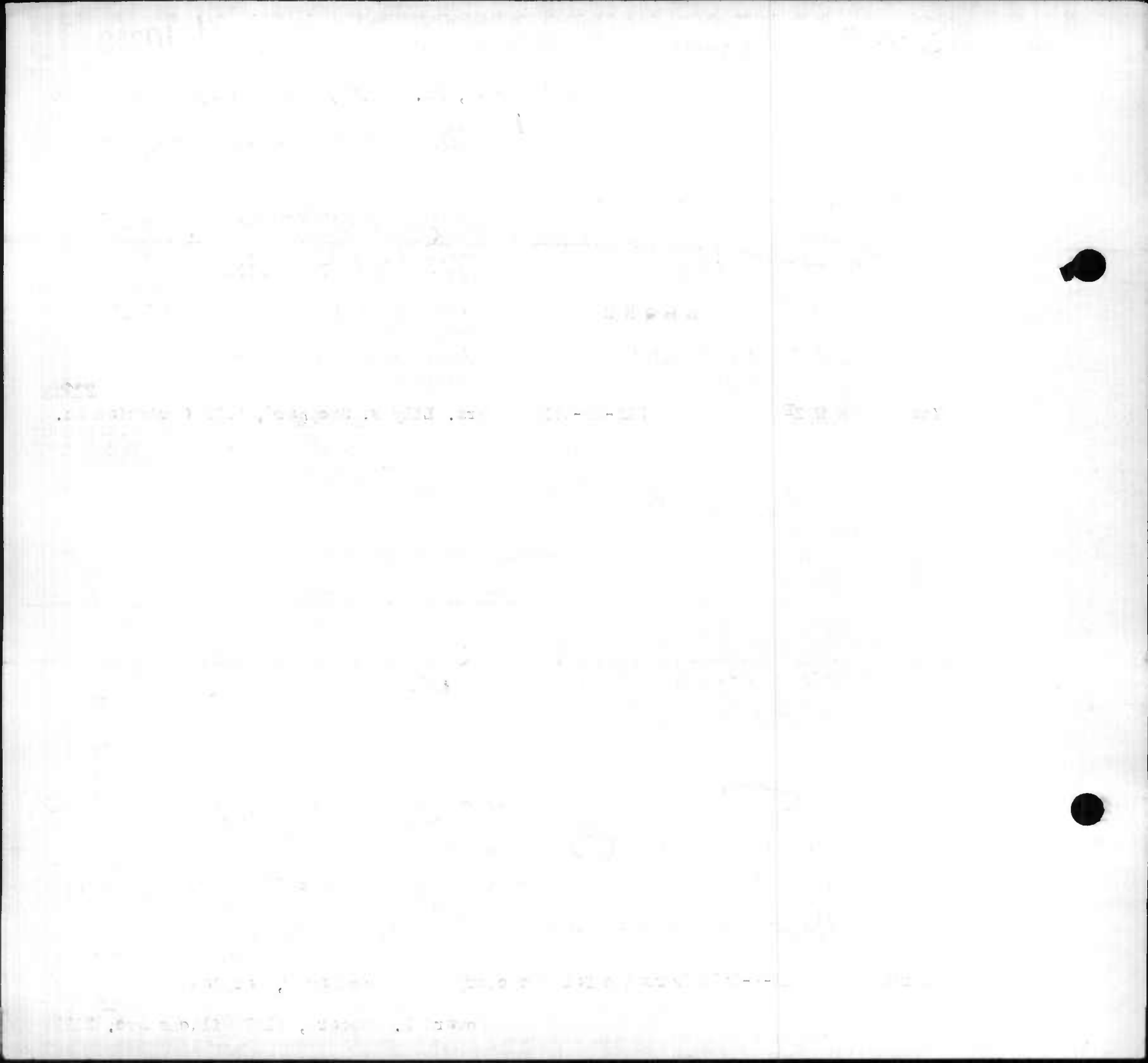
|                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                |                                              |                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------------------------|
| V-246 71 10358                                                                                                                                                                                                                                                                                                                                                    |                         | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |                                                                                                                                                                                                                                                                                                                                | 71 10358                                     |                                                              |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                         |                         | CERTIFICATE OF DEATH                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                | REG. NO.                                     |                                                              |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Elmer H. Vogler</b>                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>11/6/71 2:20 P.M.</b>                                                                                                                                                                                                                                                                          |                                              |                                                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Bon Secours Hospital</b>                                                                                                                                                            |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>1608</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>792 Linnard Street</b> |                                              |                                                              |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                             | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-23-95</b>                                                                                                                                                                                                                                                                                             | 9. AGE (In years last birthday)<br><b>76</b> | 10. Under 1 Yr. Months Days<br>11. Under 24 Hrs. Hours Min.  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                                                                                                                                                                                                                                                                                  |                                              | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 13. FATHER'S NAME<br><b>George Vogler</b>                                                                                                                                                                                                                                                                                      |                                              |                                                              |
| 14. MOTHER'S MAIDEN NAME<br><b>?</b>                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             | 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Unknown</b>                                                                                                                                                                                                      |                                              |                                                              |
| 16. SOCIAL SECURITY NO.<br><b>214-44-0319</b>                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 17. INFORMANT<br><b>Patient's Admission Sheet</b>                                                                                                                                                                                                                                                                              |                                              |                                                              |
| 18. CAUSE OF DEATH<br><b>574.1</b>                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             | 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Septicemia</b>                                                                                                        |                                              |                                                              |
| 20. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,<br><b>Generalized Peritonitis</b>                                                                                                                                                                                              |                         |                                                                                                                                                             | 21. IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Generalized Peritonitis</b>                                                                                                                                                                                                                                       |                                              |                                                              |
| 22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Carcinoma of The Liver</b>                                                                                                                                                                                             |                         |                                                                                                                                                             | 23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10-29-71 (onset)</b>                                                                                                                                                                                                                                                    |                                              |                                                              |
| 24. DATE OF OPERATION<br><b>10-25-71</b>                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CHOLECYSTITIS CHOLELITHIASIS</b>                                                                                                                                                                                                                                         |                                              |                                                              |
| 26. A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                               |                         |                                                                                                                                                             | 27. B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>NO</b>                                                                                                                                                                                                                        |                                              |                                                              |
| 28. C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 29. D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                         |                                              |                                                              |
| 30. E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 31. F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                   |                                              |                                                              |
| 32. I certify that (I) (this hospital) attended the deceased from <b>10-13</b> 19 <b>71</b> to <b>11-6</b> 19 <b>71</b><br>that (I) (we) last saw the deceased alive on <b>2:20 PM 11-6</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                |                                              |                                                              |
| 33. A. SIGNATURE<br><b>Ramiro Lindado</b>                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 34. B. DATE SIGNED<br><b>11-6-71</b>                                                                                                                                                                                                                                                                                           |                                              |                                                              |
| 35. C. PHYSICIAN'S NAME (Type)<br><b>RAMIRO LINDADO</b>                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             | 36. D. ADDRESS<br><b>Bon Secours Hospital</b>                                                                                                                                                                                                                                                                                  |                                              |                                                              |
| 37. A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 38. B. DATE<br><b>11/9/71</b>                                                                                                                                                                                                                                                                                                  |                                              |                                                              |
| 39. C. NAME OF CEMETERY or CREMATORY<br><b>Loudon Park</b>                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             | 40. D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                  |                                              |                                                              |
| 41. A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 10 1971</b>                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             | 42. B. NAME OF REGISTRAR<br><b>Robert E. Farley, M.D.</b>                                                                                                                                                                                                                                                                      |                                              |                                                              |
| 43. C. FUNERAL DIRECTOR<br><b>Witzke (Catonsville) Frederick Ave</b>                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             | 44. D. ADDRESS<br><b>1630 Edmondson Avenue</b>                                                                                                                                                                                                                                                                                 |                                              |                                                              |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

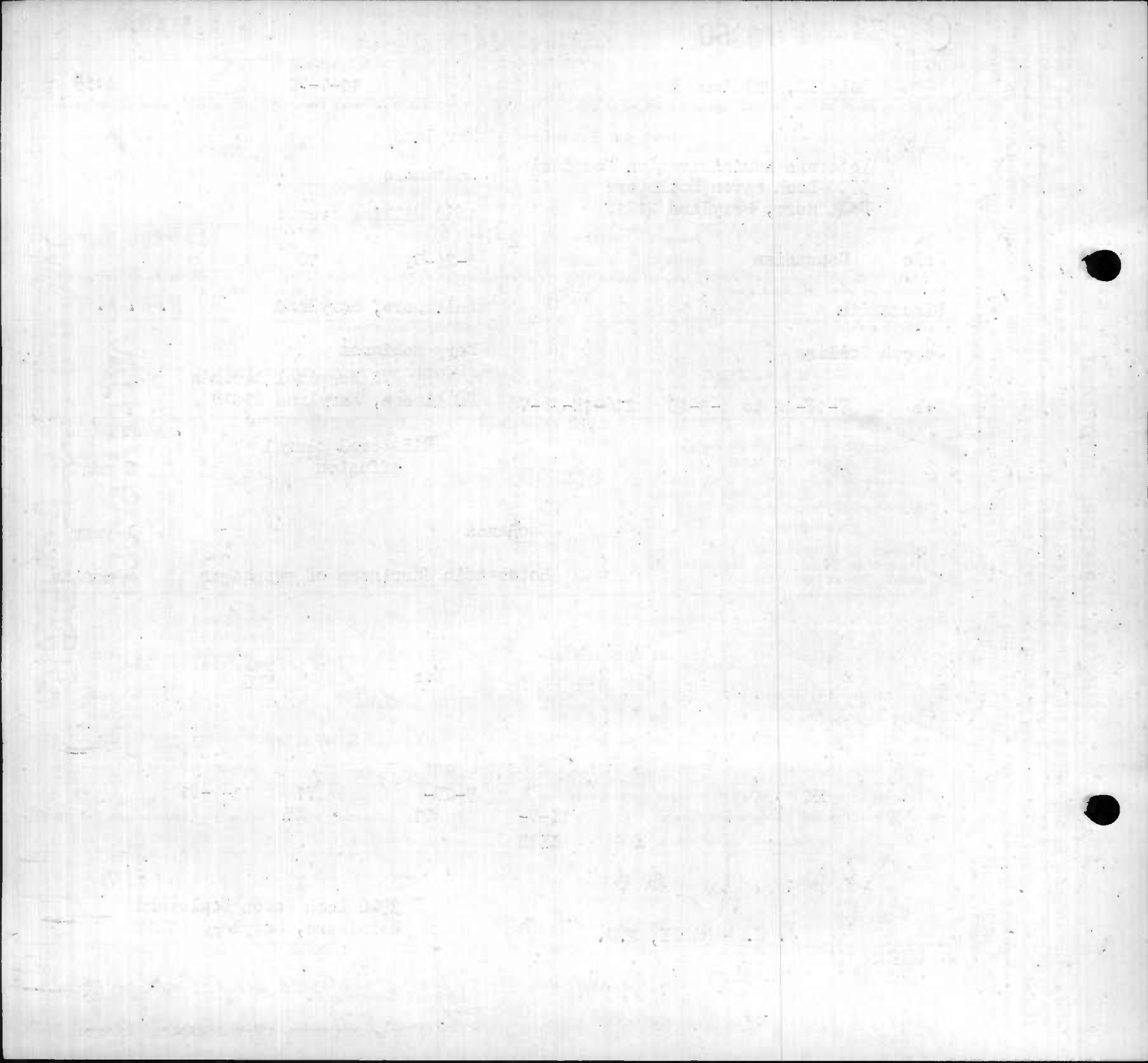
| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                | REG. NO. <u>71 10359</u>                                                                                                  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|--|
| <p><b>BIRTH NO.</b> <u>S-163 71 10359</u></p> <p><b>1. NAME OF DECEASED</b><br/>(Type or Print) <u>HAROLD B. SHEPPARD, SR.</u></p>                                                                                                                                                                                                                                    |  | <p><b>2. DATE AND HOUR OF DEATH</b><br/><u>NOV. 6, 1971 10 A.M.</u></p>                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                |                                                                                                                           |  |
| <p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br/><u>UNION MEMORIAL HOSPITAL</u></p>                                                                                                                                              |  |                                                                                                                                                                                                                                   | <p><b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution: residence before admission)<br/>A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u><br/>C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br/>E. STREET AND NUMBER <u>2525 CHRISTIAN STREET 2003</u></p> |                                                                                                                           |  |
| <p><b>5. SEX</b> <u>MALE</u> <b>6. RACE</b> <u>WHITE</u></p>                                                                                                                                                                                                                                                                                                          |  | <p><b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br/><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>                                   |                                                                                                                                                                                                                                                                                                                                                | <p><b>8. DATE OF BIRTH</b> <u>5/13/1901</u> <b>9. AGE</b> (In years last birthday) <u>70</u> <del>XXX</del></p>           |  |
| <p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED</u></p>                                                                                                                                                                                                                                              |  | <p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>B &amp; O R R</u></p>                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                | <p><b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u></p> |  |
| <p><b>13. FATHER'S NAME</b><br/><u>ALBERT SHEPPARD</u></p>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                   | <p><b>14. MOTHER'S MAIDEN NAME</b><br/><u>BERTHA LITZINGER</u></p>                                                                                                                                                                                                                                                                             |                                                                                                                           |  |
| <p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br/>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>WW II</u></p>                                                                                                                                                           |  | <p><b>16. SOCIAL SECURITY NO.</b><br/><u>213-09-9738</u></p>                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                | <p><b>17. INFORMANT</b> <u>Mrs. Lily F. Sheppard, 2525 Christian St.</u> ADDRESS <u>21223</u></p>                         |  |
| <b>CAUSE OF DEATH</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                |                                                                                                                           |  |
| <p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br/>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br/><u>Carcinoma of prostate with metastasis.</u></p>                                                                                                   |  |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                |                                                                                                                           |  |
| <p><b>19. ANTECEDENT CAUSES</b><br/>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br/><u>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</u><br/><u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u><br/><u>(C) DUE TO, OR AS A CONSEQUENCE OF:</u></p>                                                        |  |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                |                                                                                                                           |  |
| <b>II</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                |                                                                                                                           |  |
| <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                |                                                                                                                           |  |
| <p><b>19A. DATE OF OPERATION</b><br/><u>09/26/1971</u></p>                                                                                                                                                                                                                                                                                                            |  | <p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br/><u>Ca prostate with metast.</u></p>                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                | <p><b>20A. AUTOPSY?</b> (Yes or No) <u>NO</u></p>                                                                         |  |
| <p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Indify medical examiner)</p>                                                                                                                                                                                                                                                                   |  | <p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                | <p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>                                    |  |
| <p><b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)</p>                                                                                                                                                                                                                                                                                               |  | <p><b>21E. INJURY OCCURRED</b><br/>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>                                                                                                          |                                                                                                                                                                                                                                                                                                                                                | <p><b>21F. HOW DID INJURY OCCUR?</b></p>                                                                                  |  |
| <p><b>22. I certify that (1) (this hospital) attended the deceased from <u>Sept 9</u> 19 <u>71</u> to <u>11/6</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>11/6</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</b></p> |  |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                |                                                                                                                           |  |
| <p><b>23A. SIGNATURE</b><br/><u>Michael F. Scheel</u></p>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                | <p><b>23B. DATE SIGNED</b><br/><u>Nov. 6, 1971</u></p>                                                                    |  |
| <p><b>23C. PHYSICIAN'S NAME</b> (Type)<br/><u>Michael F. Scheel, M.D.</u></p>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                | <p><b>23D. ADDRESS</b><br/><u>UNION MEMORIAL HOSPITAL</u></p>                                                             |  |
| <p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br/><u>Burial</u></p>                                                                                                                                                                                                                                                                                              |  | <p><b>24B. DATE</b><br/><u>11-9-1971</u></p>                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                | <p><b>24C. NAME of CEMETERY or CREMATORY</b><br/><u>Lorraine Park Cemetery</u></p>                                        |  |
| <p><b>24D. LOCATION</b> (City, town, or county) (State)<br/><u>Woodlawn ; Maryland</u></p>                                                                                                                                                                                                                                                                            |  | <p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>NOV 10 1971</u> <b>25B. NAME OF REGISTRAR</b> <u>Robert E. Sanders, M.D.</u> <b>25C. FUNERAL DIRECTOR</b> <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u> ADDRESS <u>21229</u></p> |                                                                                                                                                                                                                                                                                                                                                |                                                                                                                           |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

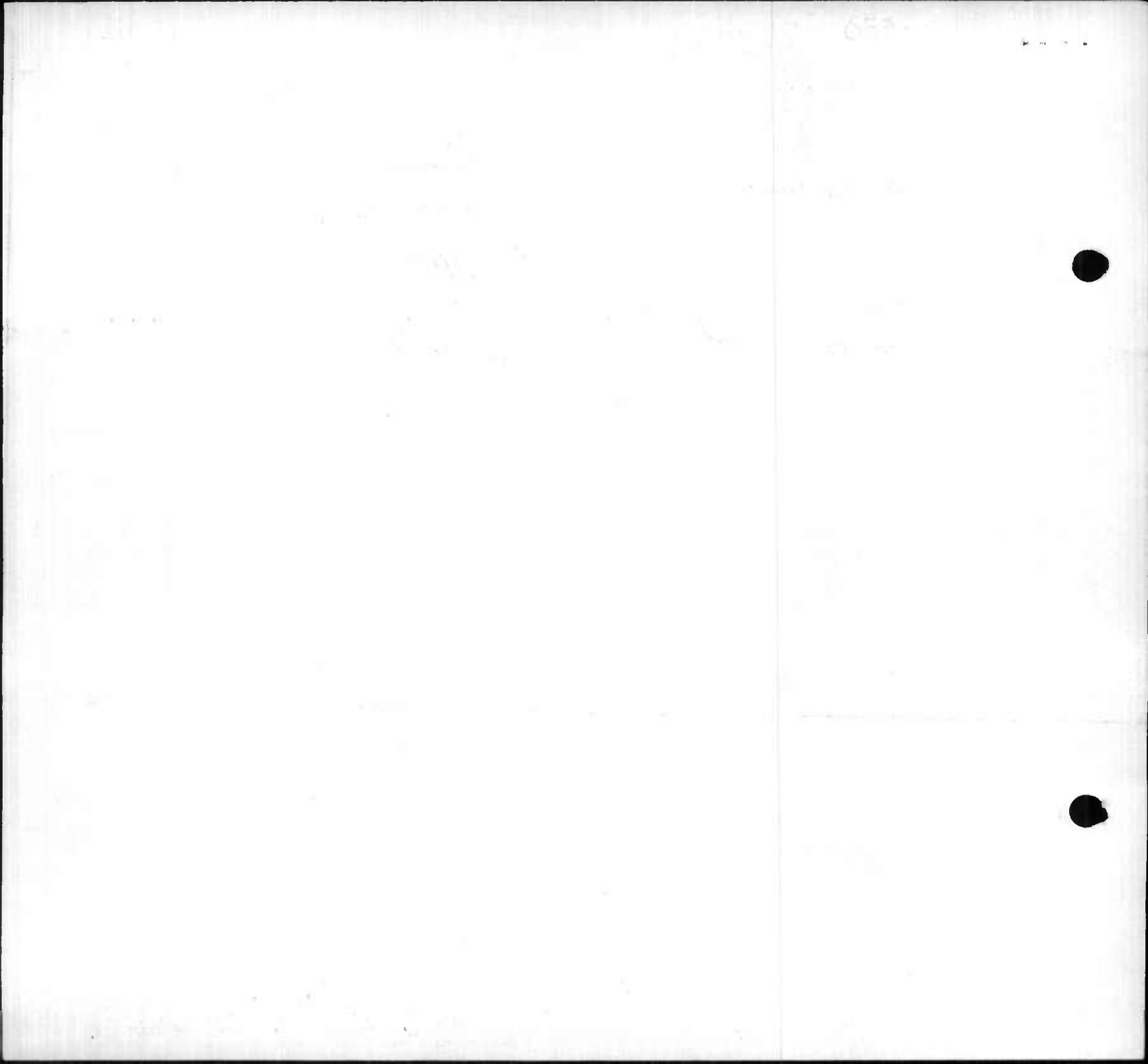
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                             |                             |                                                                                                                                                             |                                    | REG. NO. <u>71 10360</u>                                                                        |                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| 0-452 71 10360                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                             | CERTIFICATE OF DEATH                                                                                                                                        |                                    |                                                                                                 |                                                           |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             | 1. NAME OF DECEASED<br>(Type or Print) <b>COLLINS, William E</b>                                                                                            |                                    | 2. DATE AND HOUR OF DEATH<br><b>11-7-71 4:15 P.M.</b>                                           |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                       |                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>1903</b>                  |                                    |                                                                                                 |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>23 Veterans Administration Hospital</b><br><b>3900 Loch Raven Boulevard</b><br><b>Baltimore, Maryland 21218</b>                                                                                                                                                                                                                                                                                                                   |                             | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                         |                                    | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |                                                           |
| E. STREET AND NUMBER<br><b>1836 Wilkins Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                             |                                                                                                                                                             |                                    |                                                                                                 |                                                           |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 6. RACE<br><b>Caucasian</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3-24-01</b> | 9. AGE (In years last birthday)<br><b>70</b>                                                    | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Blacksmith</b>                                                                                                                                                                                                                                                                                                                                                             |                             | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>                         |                                                           |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |                             |                                                                                                                                                             |                                    |                                                                                                 |                                                           |
| 13. FATHER'S NAME<br><b>Joseph Collins</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |                             | 14. MOTHER'S MAIDEN NAME<br><b>Mary Robinson</b>                                                                                                            |                                    |                                                                                                 |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes 9-18-42 to 4-3-43</b>                                                                                                                                                                                                                                                                                                                                     |                             | 16. SOCIAL SECURITY NO.<br><b>216-18-36-78</b>                                                                                                              |                                    | 17. INFORMANT <b>VA Hospital Records</b><br><b>Baltimore, Maryland 21218</b>                    |                                                           |
| 18. CAUSE OF DEATH<br><b>Bilateral plural effusion</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b>                                                                                             |                                    |                                                                                                 |                                                           |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(B) Cachexia</b><br><b>(C) Metastatic Carcinoma of esophagus</b> |                             | <b>1 year</b><br><b>6 months</b>                                                                                                                            |                                    |                                                                                                 |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                       |                             |                                                                                                                                                             |                                    |                                                                                                 |                                                           |
| 19A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                    | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>                                                         |                                                           |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b>                                                                                                                                                                                                                                                                                                                                                                                           |                             |                                                                                                                                                             |                                    |                                                                                                 |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                        |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                    | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                     |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                    |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                    | 21F. HOW DID INJURY OCCUR?                                                                      |                                                           |
| 22. I certify that <del>XX</del> (this hospital) attended the deceased from <b>9-29-71</b> to <b>11-7-71</b> , that <del>NO</del> (we) last saw the deceased alive on <b>11-7-71</b> and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. ( <del>XX</del> (We) (did) ( <del>XXXX</del> view the body after death.                                                                                                  |                             |                                                                                                                                                             |                                    |                                                                                                 |                                                           |
| 23A. SIGNATURE<br><b>J. E. Mahaffy M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                             | 23B. DATE SIGNED<br><b>11/8/71</b>                                                                                                                          |                                    |                                                                                                 |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>J. E. MAHAFFY, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                             | 23D. ADDRESS<br><b>3900 Loch Raven Boulevard</b><br><b>Baltimore, Maryland 21218</b>                                                                        |                                    |                                                                                                 |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |                             | 24B. DATE<br><b>11-10-71</b>                                                                                                                                |                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><b>New Catholic Cemetery</b>                              |                                                           |
| 24D. LOCATION (City, town, or county) (State)<br><b>Frederick Road - Baltimore, Md</b>                                                                                                                                                                                                                                                                                                                                                                                       |                             |                                                                                                                                                             |                                    |                                                                                                 |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 10 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |                             | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>                                                                                                     |                                    | 25C. FUNERAL DIRECTOR<br><b>Thomas J. Kenny, Inc - 1600 Hollins St.</b><br><b>Baltimore, Md</b> |                                                           |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                             |                                                                                                                                                                                                                                       |                                                                                                                                                 |                                                                          |                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span>S-530 71 10361</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>71 10361</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>                                                                                                                                                                                                                                                                                                                                              |                             |                                                                                                                                                                                                                                       |                                                                                                                                                 |                                                                          |                                                                                               |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                             | 1. NAME OF DECEASED<br>(Type or Print) <u>JENNIE SMITH</u>                                                                                                                                                                            |                                                                                                                                                 | 2. DATE AND HOUR OF DEATH<br><u>NOVEMBER 6, 1971</u> <u>3:45 P</u> M.    |                                                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br><u>Gould Convalesarium</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                             |                                                                                                                                                                                                                                       | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>MD.</u> B. COUNTY <u>BALTO</u> <u>5300</u> |                                                                          |                                                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>Gould Convalesarium</u>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             |                                                                                                                                                                                                                                       | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                             |                                                                          | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                             |                                                                                                                                                                                                                                       | E. STREET AND NUMBER<br><u>1658 Myram Rd. 21204</u>                                                                                             |                                                                          |                                                                                               |
| 5. SEX<br><u>F</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 6. RACE<br><u>W</u>         | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                           |                                                                                                                                                 | 8. DATE OF BIRTH<br><u>1/11/92</u>                                       | 9. AGE (In years last birthday)<br><u>79</u>                                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Meat Cutter</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Albert F. Goetz</u>                                                                                                                                                                           |                                                                                                                                                 | 11. BIRTHPLACE (State or foreign country)<br><u>Balto. City</u>          |                                                                                               |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             | 13. FATHER'S NAME<br><u>Charles Smith</u>                                                                                                                                                                                             |                                                                                                                                                 |                                                                          |                                                                                               |
| 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth Rossen</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                             | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                 |                                                                                                                                                 |                                                                          |                                                                                               |
| 16. SOCIAL SECURITY NO.<br><u>214-24-5224</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             | 17. INFORMANT<br><u>Howard C. Allender</u>                                                                                                                                                                                            |                                                                                                                                                 |                                                                          |                                                                                               |
| 18. CAUSE OF DEATH<br><u>440.91</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><br>19A. DATE OF OPERATION<br><u>0</u> |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                      |                                                                                                                                                 | 20A. AUTOPSY? (Yes or No)                                                |                                                                                               |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                             | (A) IMMEDIATE CAUSE <u>OVERWHELMING BACTERIAL INFECTION</u> <u>4 DAYS</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) <u>ARTERIO SCLEROTIC VASCULAR DISEASE</u> <u>10 YEARS</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |                                                                                                                                                 |                                                                          |                                                                                               |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                              |                                                                                                                                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                             |                                                                                                                                                 | 21F. HOW DID INJURY OCCUR?                                               |                                                                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> 19 <u>63</u> to <u>NOV 5</u> 19 <u>71</u><br>that (I) (we) last saw the deceased alive on <u>NOV. 5</u> 19 <u>71</u> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                               |                             |                                                                                                                                                                                                                                       |                                                                                                                                                 |                                                                          |                                                                                               |
| 23A. SIGNATURE<br><u>Paul L. Long</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                             | 23B. DATE SIGNED<br><u>Nov 6/71</u>                                                                                                                                                                                                   |                                                                                                                                                 | 23C. PHYSICIAN'S NAME (Type)<br><u>MD</u>                                |                                                                                               |
| 23D. ADDRESS<br><u>523 LOCH RAVEN BLVD. BALTIMORE MD.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                             | 23E. DEGREE<br><u>MD</u>                                                                                                                                                                                                              |                                                                                                                                                 |                                                                          |                                                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 24B. DATE<br><u>11/9/71</u> | 24C. NAME OF CEMETERY or CREMATORY<br><u>Louisa Park</u>                                                                                                                                                                              |                                                                                                                                                 | 24D. LOCATION (City, town, or county) (State)<br><u>Balto., Md.</u>      |                                                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 10 1971</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                             | 25B. NAME OF REGISTRAR<br><u>John C. Miller Inc.</u>                                                                                                                                                                                  |                                                                                                                                                 | 25C. FUNERAL DIRECTOR<br><u>6415 Belair Rd.</u>                          |                                                                                               |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                                 | 71 10362                                                                                                                                                                                                                                                                                                                  |                                                                                          | REG. NO.                                                               |                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                                 | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                      |                                                                                          |                                                                        |                                            |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Caroline E. Wolf</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                                 | 2. DATE AND HOUR OF DEATH<br><b>Nov. 8, 1971</b>                                                                                                                                                                                                                                                                          |                                                                                          |                                                                        |                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Century Nursing Home<br/>102 N. Paca Street<br/>Baltimore, Md. 21201</b>                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |                                                 | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>21201</b><br>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>102 N. Paca Street</b> |                                                                                          |                                                                        |                                            |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/22/1870</b>            | 9. AGE (In years last birthday)<br><b>101</b>                                                                                                                                                                                                                                                                             | If Under 1 Yr. Months: Days:                                                             | If Under 24 Hrs. Hours: Min.                                           |                                            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>---</b> |                                                                                                                                                                                                                                                                                                                           | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                             |                                                                        | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |
| 13. FATHER'S NAME<br><b>? Sands</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>      |                                                                                                                                                                                                                                                                                                                           |                                                                                          |                                                                        |                                            |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>214-03-9929D</b>  |                                                                                                                                                                                                                                                                                                                           | 17. INFORMANT ADDRESS<br><b>2212 Eastlake Road<br/>Constance S. Cugle Timonium 21093</b> |                                                                        |                                            |
| 18. <b>412-41</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Cardio Respiratory Failure</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Seminal</b> |                         |                                                                                                                                                             |                                                 | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Congestive Heart Failure</b><br>(B) <b>Anturmelletic C U H O</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Gen. Anturmelletic</b><br>(C) <b>Seminal</b>                                                                                     |                                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |                                            |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                 | 20A. AUTOPSY? (Yes for No)                                                                                                                                                                                                                                                                                                |                                                                                          | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                                            |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                  |                                                                                          |                                                                        |                                            |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                           |                                                 | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                |                                                                                          |                                                                        |                                            |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Dec 4</b> 19 <b>63</b> to <b>Nov 8</b> 19 <b>71</b> and that (I) (we) last saw the deceased alive on <b>Nov 8</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                                                                                                                                                                                                      |                         |                                                                                                                                                             |                                                 |                                                                                                                                                                                                                                                                                                                           |                                                                                          |                                                                        |                                            |
| 23A. SIGNATURE<br><b>Willard Applefeld</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                                 | 23B. DATE SIGNED                                                                                                                                                                                                                                                                                                          |                                                                                          | 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. Willard Applefeld</b>           |                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 24B. DATE<br><b>11/10/71</b>                                                                                                                                |                                                 | 24C. NAME OF CEMETERY or CREMATORY<br><b>Woodlawn Cemetery</b>                                                                                                                                                                                                                                                            |                                                                                          | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b> |                                            |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 10 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Sabin, M.D.</b>                                                                                                      |                                                 | 25C. FUNERAL DIRECTOR <b>Eugenia K. Seitz</b> ADDRESS<br><b>Seitz Funeral Home 5209 York Rd. 21212</b>                                                                                                                                                                                                                    |                                                                                          |                                                                        |                                            |

12/4/63 - Adm.

1  
S-40071 10363  
BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
71 10363  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Thomas L. Solley</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month <b>11</b> Day <b>5</b> Year <b>71</b> Hour <b>4:22</b> a. <b>M.</b> |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 529 Maude Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 3. DATE PRONOUNCED DEAD<br>Month <b>11</b> Day <b>5</b> Year <b>71</b> Hour <b>4:22</b> a. <b>M.</b>                                                                          |  |
| 6. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 7. RACE<br><b>White</b>                                                                                                                                                       |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | C. CITY OR TOWN<br><b>Balto.</b>                                                                                                                                              |  |
| 9. DATE OF BIRTH<br><b>12/4/1907</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10. AGE (In years last birthday)<br><b>63</b>                                                                                                                                 |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. CITIZEN OF<br><b>U.S.A.</b>                                                                                                                                               |  |
| 13. FATHER'S NAME<br><b>Harry B. Solley</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>2534</b>                                           |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Annie M. Jacobs</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                       |  |
| 17. SOCIAL SECURITY NO.<br><b>217 01 6974</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 18. INFORMANT<br><b>480 Riverside Drive Mrs Edna Brooks Pasadena, Md 21122</b>                                                                                                |  |
| 19. <b>431.9</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Intracerebral hemorrhage</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Hypertensive and Arteriosclerotic cardiovascular disease</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                               |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                              |  |
| 21. AUTOPSY? (Yes or No)<br><b>yes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                               |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                      |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                               |  |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                        |  |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                               |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> DATE SIGNED <b>11/5/71</b><br>EXAMINER'S NAME (Type) |  |                                                                                                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 24B. DATE<br><b>11/9/71</b>                                                                                                                                                   |  |
| 24C. NAME of CEMETERY or CREMATORY<br><b>Cedar Hill Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore 21225, Md.</b>                                                                                                  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 10 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>                                                                                                                       |  |
| 25C. FUNERAL DIRECTOR<br><b>George J. Gonce</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | ADDRESS<br><b>4001 Ritchie Hwy Baltimore, Md 21225</b>                                                                                                                        |  |

Page 1

Page 1

*Signature*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                          |                      |                                                                                                                                                             |                                                                                                                | REG. NO. <span style="float: right;">71 10364</span>                     |                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| T-623 10364<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             |                                                                                                                |                                                                          |                                                                                               |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                 |                      | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                      |                                                                                                                | 2. DATE AND HOUR OF DEATH                                                |                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                           |                      | TROST, JOHN WILLIAM                                                                                                                                         |                                                                                                                | NOVEMBER 7, 1971 6:30 A.M.                                               |                                                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                    |                      |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                          |                                                                          |                                                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>40 ST AGNES HOSPITAL                                                                                                                                                                                                                                                                                                          |                      |                                                                                                                                                             | A. STATE<br>MARYLAND<br>B. COUNTY<br>BALTIMORE COUNTY 5300                                                     |                                                                          |                                                                                               |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                                             | C. CITY OR TOWN<br>BALTIMORE                                                                                   |                                                                          | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                           |                      |                                                                                                                                                             | E. STREET AND NUMBER<br>5810 EDMONDSON AVENUE                                                                  |                                                                          |                                                                                               |
| 5. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                            | 6. RACE<br>CAUCASIAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>10 21 91                                                                                   | 9. AGE (in years last birthday)<br>80                                    | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min.                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>RETIRED - Salesman                                                                                                                                                                                                                                                         |                      |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br>SALES                                                                     |                                                                          | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND - Baltimore                             |
| 12. CITIZEN OF WHAT COUNTRY?<br>U S A                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                                             | 13. FATHER'S NAME<br>WILLIAM TROST                                                                             |                                                                          |                                                                                               |
| 14. MOTHER'S MAIDEN NAME<br>MARY (BECHLER)                                                                                                                                                                                                                                                                                                                                |                      |                                                                                                                                                             | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No |                                                                          |                                                                                               |
| 16. SOCIAL SECURITY NO.<br>138-09-7959                                                                                                                                                                                                                                                                                                                                    |                      |                                                                                                                                                             | 17. INFORMANT<br>ST. AGNES RECORDS BALTO MD 21229                                                              |                                                                          |                                                                                               |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>412.4 I<br>Cerebral Vascular Accident<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Arterio Sclerotic Cardiovascular disease<br>(B) _____<br>(C) _____ |                      |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                   |                                                                          |                                                                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                    |                      |                                                                                                                                                             |                                                                                                                |                                                                          |                                                                                               |
| 19A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                                                               |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                | 20A. AUTOPSY? (Yes or No)<br>No                                          |                                                                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                     |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                 |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                | 21F. HOW DID INJURY OCCUR?                                               |                                                                                               |
| 22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 4 19 71 to NOVEMBER 7 19 71 that (I) (we) lost saw the deceased alive on NOVEMBER 7 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                             |                      |                                                                                                                                                             |                                                                                                                |                                                                          |                                                                                               |
| 23A. SIGNATURE<br><i>Benauides</i>                                                                                                                                                                                                                                                                                                                                        |                      |                                                                                                                                                             |                                                                                                                | 23B. DATE SIGNED<br>11 7 71                                              |                                                                                               |
| 23C. PHYSICIAN'S NAME (Type)<br>VICTOR BENAVIDES, M.D.                                                                                                                                                                                                                                                                                                                    |                      |                                                                                                                                                             |                                                                                                                | 23D. ADDRESS<br>CATON & WILKENS AVES. BALTO., MD. 21229                  |                                                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                        |                      | 24B. DATE<br>11/10/71                                                                                                                                       |                                                                                                                | 24C. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery               |                                                                                               |
| 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland                                                                                                                                                                                                                                                                                                      |                      | 24E. FUNERAL DIRECTOR<br>Sterling Swartz Estate<br>736 Edmondson Ave.<br>Catonsville, Md. 21228                                                             |                                                                                                                |                                                                          |                                                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 10 1971                                                                                                                                                                                                                                                                                                                            |                      | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, M.D.                                                                                                            |                                                                                                                | 25C. FUNERAL DIRECTOR ADDRESS                                            |                                                                                               |

23162

MAY (TECHNICAL)

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  | REG. NO. <u>71 10365</u>                                                                                                       |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO. <u>B-255-71 10365</u>                                                                                                                                                                                                                                                                                                                                                                                                           |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Sylvanah Bookman</u>                                                                                   |  |                                                                                                                                |  |
| 3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                     |  | 2. DATE AND HOUR OF DEATH<br><u>11/4/71</u> <u>12:45</u> P.M.                                                                                    |  |                                                                                                                                |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Lutheran</u>                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE _____ B. COUNTY <u>301</u>                     |  |                                                                                                                                |  |
| 5. SEX <u>M.</u> 6. RACE <u>N</u>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                               |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                |  | E. STREET AND NUMBER<br><u>3313 poplar Lane St.</u>                                                                            |  |
| 13. FATHER'S NAME<br><u>Unknown</u>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>                                                                                                       |  | 9. AGE (In years last birthday) <u>70</u>                                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) [If yes, give war or dates of service]                                                                                                                                                                                                                                                                                                                               |  | 16. SOCIAL SECURITY NO.<br><u>217-09-5091A</u>                                                                                                   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Unknown</u>                                                                    |  |
| 18. <u>43681</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>Pneumonia</u><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>Old CVA to Hemiplegia</u><br><u>Chronic brain syndrome</u> |  | 17. INFORMANT<br><u>Lutheran Hospital</u>                                                                                                        |  | 12. CITIZEN OF WHAT COUNTRY<br>ADDRESS _____                                                                                   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  |                                                                                                                                |  |
| 19A. DATE OF OPERATION<br><u>11/4/71</u>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |  | 20A. AUTOPSY? (Yes or No)<br><u>No</u>                                                                                         |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                     |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                         |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                    |  |
| 21D. TIME OF INJURY (APPROX)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                               |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                        |  | 21F. HOW DID INJURY OCCUR?                                                                                                     |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11/3</u> 19 <u>91</u> to <u>11/4</u> 19 <u>91</u> that (I) (we) last saw the deceased alive on <u>11/4</u> 19 <u>91</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                     |  |                                                                                                                                                  |  |                                                                                                                                |  |
| 23A. SIGNATURE<br><u>Young Sook Kim, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                             |  | 23B. DATE SIGNED<br><u>11/4/71</u>                                                                                                               |  | 23C. PHYSICIAN'S NAME (Type)<br><u>Young Sook Kim, M.D.</u>                                                                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                 |  | 24B. DATE<br><u>11/10/71</u>                                                                                                                     |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Mt Calvary</u>                                                                        |  |
| 24D. LOCATION<br><u>Baltimore</u>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 10 1971</u>                                                                                            |  | 25B. NAME OF REGISTRAR<br><u>Robert E. [unclear]</u>                                                                           |  |
| 25C. FUNERAL DIRECTOR<br><u>[unclear]</u>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 25D. ADDRESS<br><u>2302 W. [unclear]</u>                                                                                                         |  | 25E. [unclear]<br><u>[unclear]</u>                                                                                             |  |

9/16/71

31 S. Dallas 31



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 71 10366

G-200 71 10366  
BIRTH NO. WILLIE LEE GOUGE

|                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Gouge, Willie LEE</u>                                                                                                                                                                                                                                                                                        |  | 2. DATE AND HOUR OF DEATH<br><u>11/7/71</u> <u>8 35 P</u> M.                                                                                                                                             |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                 |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>2605</u>                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>4940 Eastern Avenue Balto, MD 21224</u><br><u>BALTIMORE CITY HOSP.</u>                                                                                                                                                                                                                                      |  | C. CITY OR TOWN <u>Baltimore</u><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                           |  |
| 5. SEX <u>Female</u><br>6. RACE <u>Caucasian</u>                                                                                                                                                                                                                                                                                                       |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                              |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                            |  | 8. DATE OF BIRTH <u>4/16/15</u><br>9. AGE (In years last birthday) <u>56</u>                                                                                                                             |  |
| 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                      |  | 11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>                                                                                                                                                   |  |
| 13. FATHER'S NAME <u>William</u>                                                                                                                                                                                                                                                                                                                       |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                                                                                                                                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>                                                                                                                                                                                                                                     |  | 16. SOCIAL SECURITY NO. <u>410-01-8396</u>                                                                                                                                                               |  |
| 17. INFORMANT <u>BCH Records - 4940 Eastern Avenue 21224</u>                                                                                                                                                                                                                                                                                           |  | ADDRESS                                                                                                                                                                                                  |  |
| 18. <u>239,91</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <u>Pulmonary Emboli</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <u>Gram negative Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <u>3/0 ABDOMINAL TUMOR</u> |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><u>II</u><br><u>HEMOLYTIC ANEMIA</u>                                                                                                                                                                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6-1 days</u><br><u>4 days</u><br><u>?</u><br><u>10 days</u>                                                                                           |  |
| 19A. DATE OF OPERATION <u>3 11/2</u>                                                                                                                                                                                                                                                                                                                   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>RECURRENT Pulm. Emboli</u>                                                                                                                           |  |
| 20A. AUTOPSY? (Yes or No) <u>YES</u>                                                                                                                                                                                                                                                                                                                   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>                                                                                                                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                                                                  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                               |  | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                              |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10/28</u> 19 <u>71</u> to <u>11/7</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11/7</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                                                                                          |  |
| 23A. SIGNATURE<br><u>Karen O'Neill MD</u>                                                                                                                                                                                                                                                                                                              |  | 23B. DATE SIGNED<br><u>11/7/71</u>                                                                                                                                                                       |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Karen O'Neill, MD</u>                                                                                                                                                                                                                                                                                               |  | 23D. ADDRESS<br><u>Baltimore city Hospitals 4940 Eastern Avenue 21224</u>                                                                                                                                |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                              |  | 24B. DATE<br><u>11/10/71</u>                                                                                                                                                                             |  |
| 24C. NAME of CEMETERY or CREMATORY<br><u>OAK LAWN</u>                                                                                                                                                                                                                                                                                                  |  | 24D. LOCATION (City, town, or county) (State)<br><u>BALTO. CO. MD</u>                                                                                                                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 10 1971</u>                                                                                                                                                                                                                                                                                                  |  | 25B. NAME OF REGISTRAR<br><u>W. Burke Dudley, Registrar, Md.</u>                                                                                                                                         |  |
| 25C. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                  |  | ADDRESS                                                                                                                                                                                                  |  |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

LACK OF INFORMATION RESTING BALTIMORE CITY HOSPITAL

SAINT JOHN'S CITY HOSPITAL

4/10/12

20

RECEIVED

310 VICTORIA TOWER

RECEIVED

RECEIVED

11/1

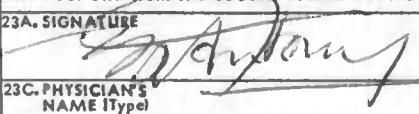
10/12/12

X

KOREAN OVER

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                |                      | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                               |                                                                                        | REG. NO. <span style="font-size: 1.2em;">71 10367</span>                                        |                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                   |                      | LEFKOWITZ, PATRICIA ALICE                                                                                                                                                                              |                                                                                        | 2. DATE AND HOUR OF DEATH<br>NOVEMBER 7, 1971 8:35A <span style="font-size: 0.8em;">a.m.</span> |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                   |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE B. COUNTY                                                                                            |                                                                                        | 5300                                                                                            |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>40 ST. AGNES HOSPITAL                                                                                                                                                                                                                                                                                                                        |                      | MARYLAND BALTIMORE 21227                                                                                                                                                                               |                                                                                        |                                                                                                 |                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                          |                      | C. CITY OR TOWN<br>Lansdowne                                                                                                                                                                           |                                                                                        | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                          |                      | E. STREET AND NUMBER<br>416 BURBANK COURT                                                                                                                                                              |                                                                                        |                                                                                                 |                                                           |
| 5. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                         | 6. RACE<br>CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                            | 8. DATE OF BIRTH<br>07 15 36                                                           | 9. AGE (In years last birthday)<br>35                                                           | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife                                                                                                                                                                                                                                                                                 |                      | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                      |                                                                                        | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND                                           |                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                          |                      |                                                                                                                                                                                                        |                                                                                        | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                          |                                                           |
| 13. FATHER'S NAME<br>WILLIAM M. SULLIVAN                                                                                                                                                                                                                                                                                                                                                 |                      | 14. MOTHER'S MAIDEN NAME<br>LILLIAN (NORFOLK)                                                                                                                                                          |                                                                                        |                                                                                                 |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO None                                                                                                                                                                                                                                                                      |                      | 16. SOCIAL SECURITY NO.<br>212-32-1199                                                                                                                                                                 | 17. INFORMANT<br>WILKENS AVES. BALTO., MD. 21229<br>ST. AGNES HOSPITAL RECORDS-CATON & |                                                                                                 |                                                           |
| 18. <span style="font-size: 1.2em;">485X I</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                      | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>Respiratory Failure<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) BronchoPneumonia with Abscess left upper lobe<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) |                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                    |                                                           |
| II                                                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                                                                        |                                                                                        |                                                                                                 |                                                           |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                         |                      |                                                                                                                                                                                                        |                                                                                        |                                                                                                 |                                                           |
| 19A. DATE OF OPERATION<br>2                                                                                                                                                                                                                                                                                                                                                              |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                       |                                                                                        | 20A. AUTOPSY (Yes or No)<br>YES                                                                 |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                                                                                    |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                                                                |                                                                                        | 21C. WHERE DID INJURY OCCUR<br>(If in Baltimore City, give exact location)                      |                                                           |
| 21D. TIME OF INJURY (Approx.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                             |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                              |                                                                                        | 21F. HOW DID INJURY OCCUR?                                                                      |                                                           |
| 22. I certify that (X) (this hospital) attended the deceased from <u>OCTOBER 30, 1971</u> to <u>NOVEMBER 7, 1971</u> (that X) (we) last saw the deceased alive on <u>NOVEMBER 7, 1971</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.                                        |                      |                                                                                                                                                                                                        |                                                                                        |                                                                                                 |                                                           |
| 23A. SIGNATURE<br>                                                                                                                                                                                                                                                                                    |                      | 23B. DATE SIGNED<br>11 07 71                                                                                                                                                                           |                                                                                        |                                                                                                 |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br>T.P. ANTONY M.D.                                                                                                                                                                                                                                                                                                                                         |                      | 23D. ADDRESS<br>CATON & WILKENS AVES. BALTO., MD. 21229                                                                                                                                                |                                                                                        |                                                                                                 |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                       |                      | 24B. DATE<br>11/10/1971                                                                                                                                                                                |                                                                                        | 24C. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith                                          |                                                           |
| 24D. LOCATION<br>Baltimore County, Maryland                                                                                                                                                                                                                                                                                                                                              |                      | 24E. NAME OF REGISTRAR<br>Robert E. Taylor, R.S.                                                                                                                                                       |                                                                                        | 24F. FUNERAL DIRECTOR<br>8728 Liberty Rd. ADDRESS 21133<br>Loring Byers Funeral Directors, P.A. |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 10 1971                                                                                                                                                                                                                                                                                                                                           |                      | 25B. NAME OF REGISTRAR                                                                                                                                                                                 |                                                                                        | 25C. FUNERAL DIRECTOR                                                                           |                                                           |

ST. JAMES HOSPITAL

PAULINE CAUGHRAN

WILLIAM M. SULLIVAN

WILLIAM (BOBBY)

11-1-1932

OCTOBER 30, 1931

RECEIVED

ST. JAMES HOSPITAL

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10368

BIRTH NO. B-400 71 10368

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                    |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Harold Bell</b>                                                                                                                                                                                                                                                                                                                                                     |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>11 6 71 798 A.M.</b> |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>33 Johns Hopkins Hosp.</b>                                                                                                                                                                                                                                                                               |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>11 6 71 743 A.M.</b>                                                                          |  |
| 6. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                                                                               |  | 7. RACE <b>cauc.</b>                                                                                                                               |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                   |  | 5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>908</b>                   |  |
| 9. DATE OF BIRTH <b>12/9/02</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 10. AGE (in years last birthday) <b>69</b>                                                                                                         |  |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                     |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                            |  |
| 13. FATHER'S NAME <b>John Bell</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labourer</b>                                         |  |
| 15. MOTHER'S MAIDEN NAME <b>?</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>                                 |  |
| 17. SOCIAL SECURITY NO. <b>#</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 18. INFORMANT <b>Mrs Eva Puckett</b> ADDRESS <b>2331 Greenmount Ave</b>                                                                            |  |
| 19. <b>E 8871</b>                                                                                                                                                                                                                                                                                                                                                                                             |  | CAUSE OF DEATH                                                                                                                                     |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Subdural Hematoma</b>                                                                 |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                              |  | (C)                                                                                                                                                |  |
| 20A. DATE OF OPERATION <b>2</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                               |  | 22B. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) <b>Street</b>                                                   |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>00-00</b>                                                                                                                                                                                                                                                                                                                         |  | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>11 3 71</b>                                                                           |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                             |  | 22F. HOW DID INJURY OCCUR? <b>presumably Fell</b>                                                                                                  |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                                    |  |
| ACTUAL SIGNATURE <b>Werner U. Spitz</b> EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                |  | DATE SIGNED <b>11. 6. 71</b>                                                                                                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                        |  | 24B. DATE <b>11/9/71</b>                                                                                                                           |  |
| 24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary</b>                                                                                                                                                                                                                                                                                                                                                          |  | 24D. LOCATION (City, town, or county) (State) <b>Brooklyn A.A. Co md</b>                                                                           |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 10 1971</b>                                                                                                                                                                                                                                                                                                                                                            |  | 25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>                                                                                               |  |
| 25C. FUNERAL DIRECTOR <b>Burnell S. Allen - Balto, Md.</b>                                                                                                                                                                                                                                                                                                                                                    |  | ADDRESS <b>1735 Maryland Ave #212</b>                                                                                                              |  |

N 8534018309





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <p><b>B-435 71 10369</b></p> <p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>                                                                                                                                                                                                                                                  |  | <p>REG. NO. <b>71 10369</b></p>                                                                                                                                                                                                                    |  |
| <p><b>BIRTH NO.</b></p>                                                                                                                                                                                                                                                                                                                                         |  | <p><b>2. DATE AND HOUR OF DEATH</b></p>                                                                                                                                                                                                            |  |
| <p><b>1. NAME OF DECEASED</b><br/>(Type or Print)</p> <p style="text-align: center;"><b>MARY GOLDMAN</b></p>                                                                                                                                                                                                                                                    |  | <p><b>NOVEMBER 6, 1971</b> <span style="float: right;"><b>1:05 A.M.</b></span></p>                                                                                                                                                                 |  |
| <p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>                                                                                                                                                                                                                                                                                            |  | <p><b>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</b></p>                                                                                                                                                |  |
| <p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><b>6518 EBERLE DRIVE, APT. 2 A</b></p>                                                                                                                                                                                               |  | <p><b>MARYLAND</b></p>                                                                                                                                                                                                                             |  |
| <p><b>5. SEX</b> <b>FEMALE</b></p>                                                                                                                                                                                                                                                                                                                              |  | <p><b>6. RACE</b> <b>WHITE</b></p>                                                                                                                                                                                                                 |  |
| <p><b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/></p> <p><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>                                                                                                                                                              |  | <p><b>8. DATE OF BIRTH</b></p>                                                                                                                                                                                                                     |  |
| <p><b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b></p> <p><b>HOUSEWIFE</b></p>                                                                                                                                                                                                                               |  | <p><b>9. AGE (In years last birthday)</b> <b>68</b></p>                                                                                                                                                                                            |  |
| <p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p> <p><b>AT HOME</b></p>                                                                                                                                                                                                                                                                                           |  | <p><b>11. BIRTHPLACE (State or foreign country)</b></p> <p><b>BALTIMORE, MARYLAND</b></p>                                                                                                                                                          |  |
| <p><b>13. FATHER'S NAME</b></p> <p><b>? HALL</b></p>                                                                                                                                                                                                                                                                                                            |  | <p><b>12. CITIZEN OF WHAT COUNTRY?</b></p> <p><b>USA</b></p>                                                                                                                                                                                       |  |
| <p><b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b></p> <p><b>NO</b></p>                                                                                                                                                                                                                         |  | <p><b>16. SOCIAL SECURITY NO.</b></p>                                                                                                                                                                                                              |  |
| <p><b>17. INFORMANT</b></p> <p><b>MR. ABRAHAM GOLDMAN, 6518 EBERLE DR., APT. 2A</b></p>                                                                                                                                                                                                                                                                         |  | <p><b>ADDRESS</b></p>                                                                                                                                                                                                                              |  |
| <p><b>18. CAUSE OF DEATH</b></p>                                                                                                                                                                                                                                                                                                                                |  | <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>                                                                                                                                                                                         |  |
| <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> |  | <p><b>(A) IMMEDIATE CAUSE</b> <u>Myocardial Infarction</u> <b>minutes</b></p> <p><b>DUE TO, OR AS A CONSEQUENCE OF:</b></p> <p><b>(B)</b> <u>Arteriosclerosis</u> <b>years</b></p> <p><b>DUE TO, OR AS A CONSEQUENCE OF:</b></p> <p><b>(C)</b></p> |  |
| <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b></p>                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                    |  |
| <p><b>19A. DATE OF OPERATION</b></p>                                                                                                                                                                                                                                                                                                                            |  | <p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>                                                                                                                                                                                     |  |
| <p><b>20A. AUTOPSY? (Yes or No)</b></p>                                                                                                                                                                                                                                                                                                                         |  | <p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>                                                                                                                                                                 |  |
| <p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> <input type="checkbox"/> <b>Inally medical examined</b></p>                                                                                                                                                                                                                               |  | <p><b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b></p>                                                                                                                                             |  |
| <p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>                                                                                                                                                                                                                                                                          |  | <p><b>21D. TIME OF INJURY (Approx.)</b> (Month) (Day) (Year) (Hour)</p>                                                                                                                                                                            |  |
| <p><b>21E. INJURY OCCURRED</b></p> <p><b>While At Work</b> <input type="checkbox"/> <b>Not While At Work</b> <input type="checkbox"/></p>                                                                                                                                                                                                                       |  | <p><b>21F. HOW DID INJURY OCCUR?</b></p>                                                                                                                                                                                                           |  |
| <p><b>22. I certify that (I) (this hospital) attended the deceased from <u>January 1971</u> to <u>November 6, 1971</u> that (I) (we) last saw the deceased alive on <u>Oct 27, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>        |  |                                                                                                                                                                                                                                                    |  |
| <p><b>23A. SIGNATURE</b></p> <p><i>David I. Miller</i></p>                                                                                                                                                                                                                                                                                                      |  | <p><b>23B. DATE SIGNED</b></p> <p><u>Nov-6-71</u></p>                                                                                                                                                                                              |  |
| <p><b>23C. PHYSICIAN'S NAME (Type)</b></p> <p><b>DAVID I. MILLER</b></p>                                                                                                                                                                                                                                                                                        |  | <p><b>23D. ADDRESS</b></p> <p><b>9115 REISTERSTOWN ROAD</b></p>                                                                                                                                                                                    |  |
| <p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b></p> <p><b>BURIAL</b></p>                                                                                                                                                                                                                                                                                     |  | <p><b>24B. DATE</b></p> <p><b>11-8-71</b></p>                                                                                                                                                                                                      |  |
| <p><b>24C. NAME OF CEMETERY OR CREMATORY</b></p> <p><b>PROGRESSIVE SICK BENEFIT &amp; RELIEF ASSOC.</b></p>                                                                                                                                                                                                                                                     |  | <p><b>24D. LOCATION</b> (City, town, or county) (State)</p> <p><b>RANDALLSTOWN, MARYLAND</b></p>                                                                                                                                                   |  |
| <p><b>25A. DATE REC'D BY HEALTH DEPT.</b></p> <p><b>NOV 10 1971</b></p>                                                                                                                                                                                                                                                                                         |  | <p><b>25B. NAME OF REGISTRAR</b></p> <p><b>SOL LEVINSON &amp; BROS.</b></p>                                                                                                                                                                        |  |
| <p><b>25C. FUNERAL DIRECTOR</b></p> <p><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b></p>                                                                                                                                                                                                                                                              |  | <p><b>ADDRESS</b></p>                                                                                                                                                                                                                              |  |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <b>K-613</b> <b>71 10370</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                          |                                                                                                                                                             |                                     | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                           |                            | REG. NO. <b>71 10370</b>                                                                      |                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------------------------------------------------------------|-----------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>KRAVETZ, JANK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                                                                                                                                                             |                                     | 2. DATE AND HOUR OF DEATH<br><b>11/06/71</b> <b>9:40AM</b> M.                                                                              |                            |                                                                                               |                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                          |                                                                                                                                                             |                                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>1510</b> |                            |                                                                                               |                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>ST AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                        |                                     | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                        |                            | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                             |
| <b>CERTIFICATE AMENDED 11/10/71</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                          |                                                                                                                                                             |                                     | E. STREET AND NUMBER<br><b>4012 BELLE AVENUE 21215</b>                                                                                     |                            |                                                                                               |                             |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. RACE <b>CAUCASIAN</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>09/06/12</b> | 9. AGE (In years last birthday)<br><b>59</b>                                                                                               | If Under 1 Yr. Months Days |                                                                                               | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>US POST OFFICE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                          | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>POSTAL CLERK</b>                                                                                                    |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE MARYLAND</b>                                                                     |                            | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                                                  |                             |
| 13. FATHER'S NAME<br><b>ISRAEL KRAVETZ</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                          |                                                                                                                                                             |                                     | 14. MOTHER'S MAIDEN NAME<br><b>REBECCA (YAFFE)</b>                                                                                         |                            |                                                                                               |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          | 16. SOCIAL SECURITY NO.<br><b>2 13 16 5247</b>                                                                                                              |                                     | 17. INFORMANT <b>MRS. DOROTHY FRUSH</b>                                                                                                    |                            | ADDRESS<br><b>4012 BELLE AVENUE #21215</b>                                                    |                             |
| 18. <b>CAUSE OF DEATH</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Sudden Respiratory Failure</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last<br><b>Antecedent Cause - Pulmonary Edema</b><br><b>Salicylate Intoxication</b><br><b>Medication Intoxication</b><br><b>Alcohol Intoxication</b><br><b>Respiratory Intoxication</b> |                          |                                                                                                                                                             |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 hrs.</b>                                                                             |                            |                                                                                               |                             |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                                                                                                                                                             |                                     |                                                                                                                                            |                            |                                                                                               |                             |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                          | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                     | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                                                                     |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                          | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Dwelling</b>                                                 |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>30 Franklin Rd 53-00</b>                                    |                            |                                                                                               |                             |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)<br><b>11-5-71</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>                                        |                                     | 21F. HOW DID INJURY OCCUR?<br><b>top overdose of aspirin</b>                                                                               |                            |                                                                                               |                             |
| 22. I certify that (X) (this hospital) attended the deceased from <b>11/05/71</b> 19 to <b>11/06/71</b> 19<br>that (X) (we) last saw the deceased alive on <b>11/06/71</b> 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                |                          |                                                                                                                                                             |                                     |                                                                                                                                            |                            |                                                                                               |                             |
| 23A. SIGNATURE<br><b>SUROR ALAM M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                          |                                                                                                                                                             |                                     | 23B. DATE SIGNED<br><b>11/6/71</b>                                                                                                         |                            | 23C. PHYSICIAN'S NAME (Type)<br><b>SUROR ALAM M.D.</b>                                        |                             |
| 23D. ADDRESS<br><b>CATON &amp; WILKENS AVES. BALTO., MD. 21229</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                          |                                                                                                                                                             |                                     |                                                                                                                                            |                            |                                                                                               |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                          | 24B. DATE<br><b>11-7-71</b>                                                                                                                                 |                                     | 24C. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW FRIENDSHIP</b>                                                                             |                            | 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE, MARYLAND</b>                   |                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 10 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          | 25B. NAME OF REGISTRAR<br><b>Robert E. Sabin, R.D.</b>                                                                                                      |                                     | 25C. FUNERAL DIRECTOR ADDRESS<br><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>                                                   |                            |                                                                                               |                             |

Spelling of Item 6 and given name of Item 13 changed--SMN

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                                                       |                                    |                                                                                               |                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------|
| A-536 71 10371                                                                                                                                                                                                                                                                                                                                              |                         | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                      |                                    | REG. NO. 71 10371                                                                             |                                          |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                   |                         | CERTIFICATE OF DEATH                                                                                                                                                                  |                                    |                                                                                               |                                          |
| 1. NAME OF DECEASED<br>(Type or Print) <u>WILLIE ANDERSON</u>                                                                                                                                                                                                                                                                                               |                         | 2. DATE AND HOUR OF DEATH<br><u>11-3-71</u> <u>7:40 A.M.</u>                                                                                                                          |                                    |                                                                                               |                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>THE JOHNS HOPKINS HOSPITAL</u>                                                                                                                                                |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>MARYLAND</u><br>B. COUNTY <u>833</u>                                             |                                    |                                                                                               |                                          |
|                                                                                                                                                                                                                                                                                                                                                             |                         | C. CITY OR TOWN<br><u>BALTIMORE</u>                                                                                                                                                   |                                    | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                          |
|                                                                                                                                                                                                                                                                                                                                                             |                         | E. STREET AND NUMBER<br><u>2638 E. BIDDLE ST.</u>                                                                                                                                     |                                    |                                                                                               |                                          |
| 5. SEX<br><u>MALE</u>                                                                                                                                                                                                                                                                                                                                       | 6. RACE<br><u>NEGRO</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                      | 8. DATE OF BIRTH<br><u>2-13-07</u> | 9. AGE (In years last birthday)<br><u>64</u>                                                  | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                 |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                     |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>NORTH CAROLINA</u>                            |                                          |
| 13. FATHER'S NAME<br><u>UNKNOWN</u>                                                                                                                                                                                                                                                                                                                         |                         | 14. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u>                                                                                                                                            |                                    |                                                                                               |                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                    |                         | 16. SOCIAL SECURITY NO.                                                                                                                                                               |                                    | 17. INFORMANT<br><u>FLORIANE LEWIS</u> ADDRESS <u>962 N. CHESTER ST</u>                       |                                          |
| 18. <u>00371-503-2</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |                         | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <u>Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <u>Salmonella sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr.</u><br><u>2 days</u>                 |                                          |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                      |                         | <u>Chronic Ethanolism</u>                                                                                                                                                             |                                    |                                                                                               |                                          |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                          |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                      |                                    | 20A. AUTOPSY? (Yes or No)                                                                     |                                          |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                       |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                                               |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                          |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                   |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                |                                    | 21F. HOW DID INJURY OCCUR?                                                                    |                                          |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11-1</u> 19 <u>71</u> to <u>11-3</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11-3</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.       |                         |                                                                                                                                                                                       |                                    |                                                                                               |                                          |
| 23A. SIGNATURE<br><u>M. Hollenberg D. Phil.</u>                                                                                                                                                                                                                                                                                                             |                         | 23B. DATE SIGNED<br><u>11-3-71</u>                                                                                                                                                    |                                    | 23C. PHYSICIAN'S NAME (Type)<br><u>M. D. HOLLENBERG M.D.</u>                                  |                                          |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                                   |                         | 24B. DATE<br><u>11-8-71</u>                                                                                                                                                           |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><u>MT HUBURN</u>                                        |                                          |
| 24D. LOCATION<br><u>BALTO. MD.</u>                                                                                                                                                                                                                                                                                                                          |                         | 24E. ADDRESS<br><u>THE JOHNS HOPKINS HOSPITAL</u>                                                                                                                                     |                                    | 24F. ADDRESS<br><u>AVE</u>                                                                    |                                          |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 10 1971</u>                                                                                                                                                                                                                                                                                                       |                         | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, R.D.</u>                                                                                                                               |                                    | 25C. FUNERAL DIRECTOR<br><u>E. O. Wilson</u> ADDRESS <u>1000 BRANTLEY</u>                     |                                          |

1971

1972

1973

1974

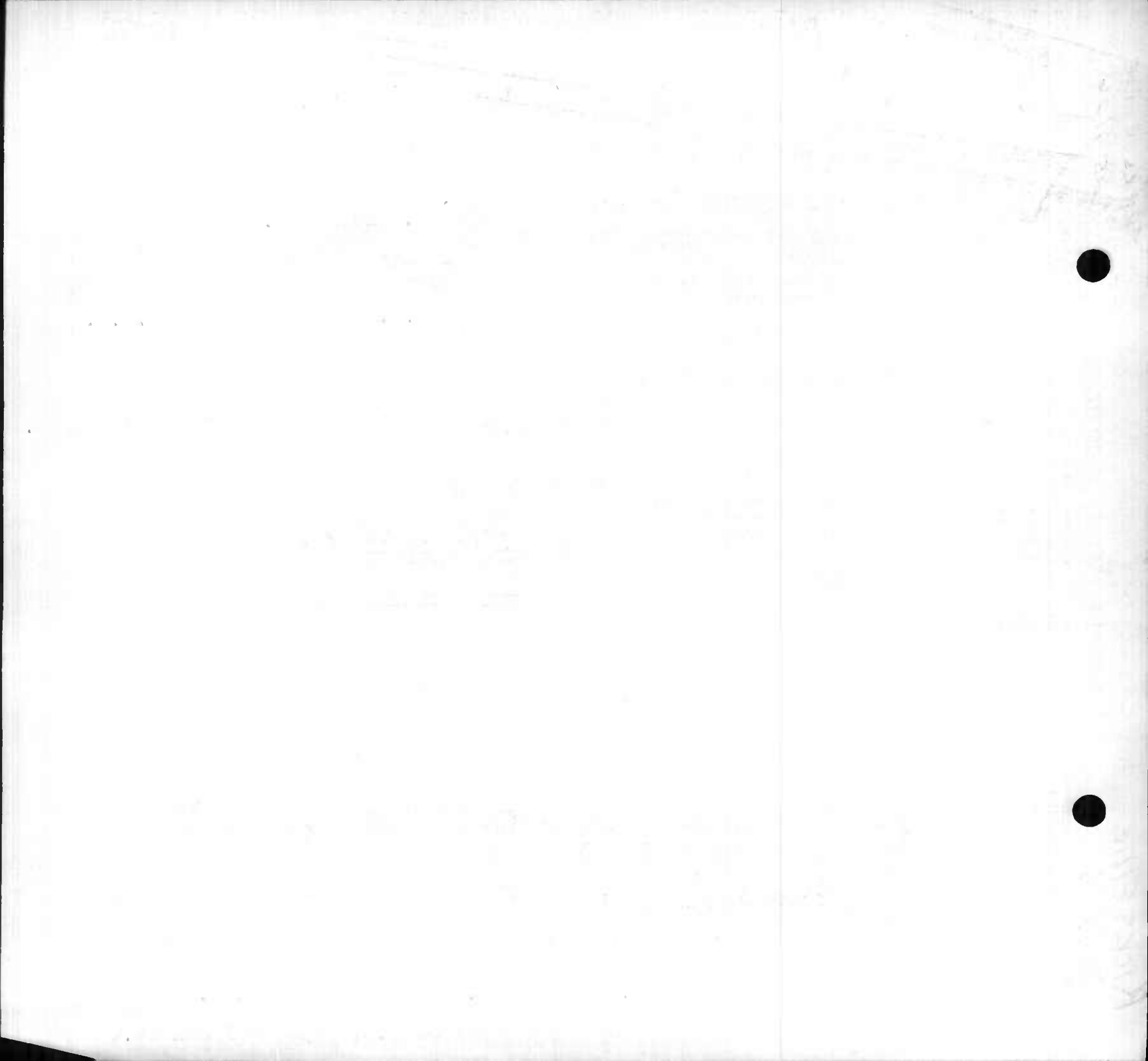
1975

1976

Ricks, Ellie  
259126  
Funeral Director: Important  
Released Non-Med - Dr Spitz

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  |                                                                                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| R-200 71 10372                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                          |  | 71 10372                                                                                                                                                    |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | CERTIFICATE OF DEATH                                                                                      |  | REG. NO.                                                                                                                                                    |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                               |  | RICKS, Ellie (Elie)                                                                                       |  | 2. DATE AND HOUR OF DEATH<br>11/7/71 3:58 PM                                                                                                                |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                     |  | A. STATE<br>Maryland                                                                                                                                        |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>33 The Johns Hopkins Hospital                                                                                                                                                                                                                                                                                                                                                                                                |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                      |  | B. COUNTY<br>1001                                                                                                                                           |  |
| 5. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 6. RACE<br>Negro                                                                                          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |
| 8. DATE OF BIRTH<br>12-25-14                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 9. AGE (in years)<br>58                                                                                   |  | 10. UNDER 1 Yr. Months Days<br>11. UNDER 24 Hrs. Hours Min.                                                                                                 |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                          |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                         |  | 11. BIRTHPLACE (State or foreign country)<br>N.C.                                                                                                           |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 14. MOTHER'S MAIDEN NAME                                                                                  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service)<br>no                                                                                                                                                                                                                                                                                                                                                    |  | 16. SOCIAL SECURITY NO.<br>214-16-6629HA                                                                  |  | 17. INFORMANT<br>Reddick Ricks 2117 Braddish Ave.                                                                                                           |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>560.9 I<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>aspiration                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |
| (B) small bowel obstruction<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                                                                                                                       |  | (C)                                                                                                       |  |                                                                                                                                                             |  |
| 19A. DATE OF OPERATION<br>2                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20A. AUTOPSY? (Yes or No)<br>Yes                                                                                                                            |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                       |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>NO                                                                              |  |
| 21D. TIME OF INJURY (APPROX.)<br>1 (Month) (Day) 1 (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                     |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |
| 22. I certify that (A) (this hospital) attended the deceased from 11/7/71 19 to 11/7/71 19 that (B) (we) last saw the deceased alive on 3:35 PM 11/7/71 19 and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death.                                                                                                                                                   |  | 23A. SIGNATURE<br>Walter L. Gerber, MD                                                                    |  | 23B. DATE SIGNED<br>11/7/71                                                                                                                                 |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Walter L. Gerber, M.D.                                                                                                                                                                                                                                                                                                                                                                                                               |  | 23D. ADDRESS<br>The Johns Hopkins Hospital                                                                |  |                                                                                                                                                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 24B. DATE<br>11-11-71                                                                                     |  | 24C. NAME of CEMETERY or CREMATORY<br>Mt. Auburn Cem.                                                                                                       |  |
| 24D. LOCATION<br>Baltimore, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 24E. CITY, town, or county<br>Baltimore, Md.                                                              |  | 24F. STATE<br>Md.                                                                                                                                           |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 10 1971                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 25B. NAME OF REGISTRAR<br>John F. Bailey                                                                  |  | 25C. FUNERAL DIRECTOR<br>V. Bailey                                                                                                                          |  |
| 25D. ADDRESS<br>1348 Calhoun St.                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 25E. ADDRESS<br>1348 Calhoun St.                                                                          |  | 25F. ADDRESS                                                                                                                                                |  |



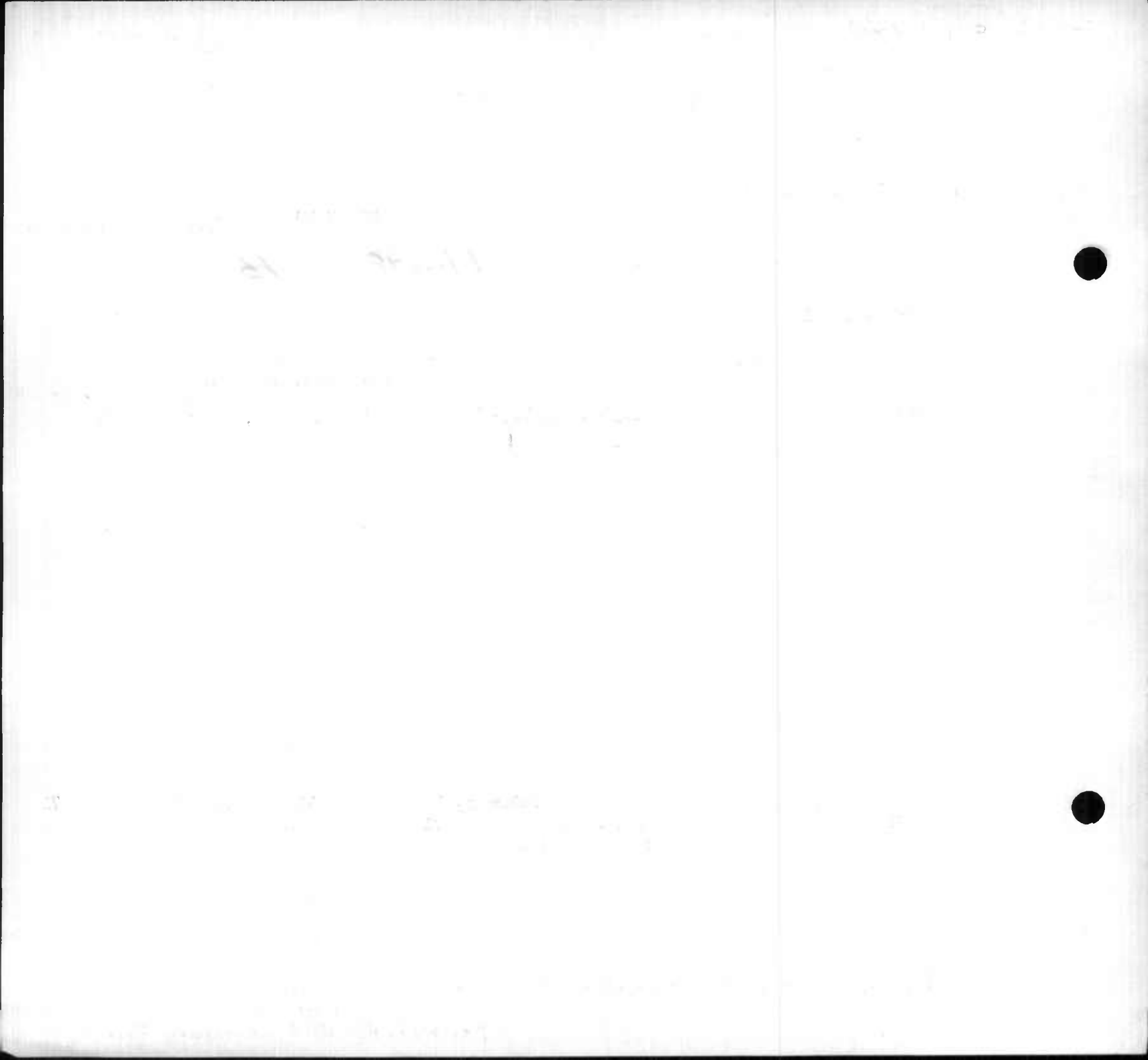
## CERTIFICATE OF DEATH

REG. NO. 71 10373

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

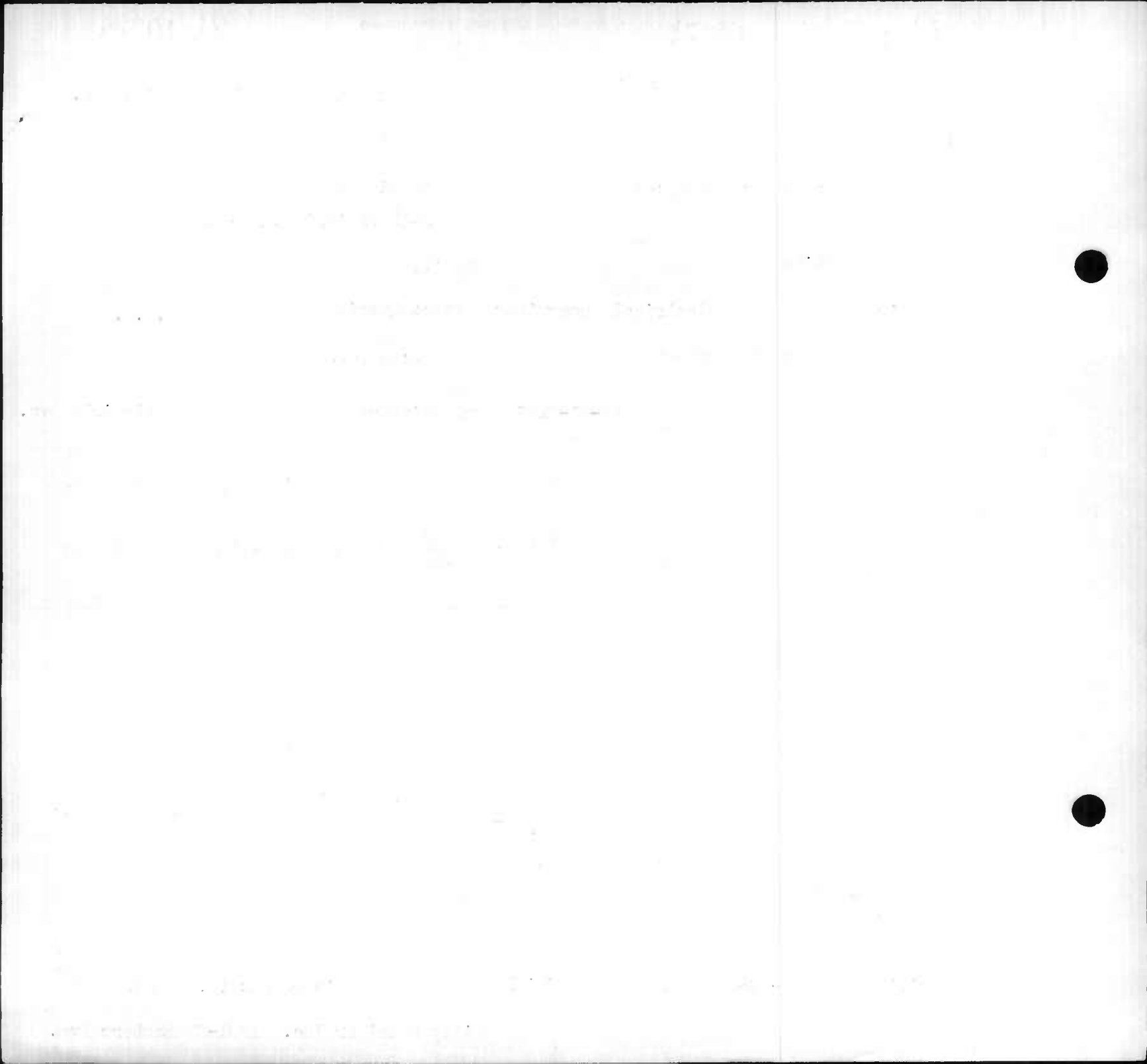
|                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                     |  |                                                                    |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|--|
| BIRTH NO. C-640                                                                                                                                                                                                                                                                                                                       |                  | 71 10373                                                                                                                                                    |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                               |  | CERTIFICATE OF DEATH                                                                                                |  | REG. NO. 71 10373                                                  |  |
| 1. NAME OF DECEASED<br>(Type or Print) CARROLL, CECILIA (Celia)                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br>Nov. 8, 1971 4:10 P.M.                                                                                                                                                                                                                                                                            |  |                                                                                                                     |  |                                                                    |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>BALTIMORE CITY HOSP. 4940 Eastern Avenue<br>BALTIMORE, Md 21224                                                                                                |                  |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE Md. B. COUNTY Baltimore 1601<br>C. CITY OR TOWN Baltimore<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 4940 Eastern Avenue, 21224 1129 STOCKTON ST. |  |                                                                                                                     |  |                                                                    |  |
| 5. SEX<br>♀                                                                                                                                                                                                                                                                                                                           | 6. RACE<br>NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>1/18/98                                                                                                                                                                                                                                                                                                    |  | 9. AGE (in years last birthday)<br>73                                                                               |  | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.      |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>DOMESTIC                                                                                                                                                                                                                               |                  |                                                                                                                                                             |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                              |  | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND                                                               |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                |  |
| 13. FATHER'S NAME<br>PAUL SHARPS                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br>CECELIA EVANS Md                                                                                                                                                                                                                                                                                   |  |                                                                                                                     |  |                                                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO                                                                                                                                                                                                                        |                  |                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.<br>212-16-0726A                                                                                                                                                                                                                                                                                        |  | 17. INFORMANT MARY WILLIAMS-1129 ADDRESS 4940 Eastern Avenue STOCKTON ST. BALTIMORE, Maryland 21224<br>BCH RECORDS: |  |                                                                    |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |                                                                                                                                                             |  | CAUSE OF DEATH<br>Myocardial Infarction<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Diabetes Mellitus.<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C)                                                                                                                                                          |  |                                                                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 hrs.<br>7 5 yrs. |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                |                  |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                     |  |                                                                    |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)<br>NO                                                                                                                                                                                                                                                                                                |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                |  |                                                                    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                 |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                       |  |                                                                                                                     |  |                                                                    |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                             |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                     |  |                                                                                                                     |  |                                                                    |  |
| 22. I certify that (1) (this hospital) attended the deceased from February 7, 1971 to November 8, 1971 that (1) (we) last saw the deceased alive on November 8, 1971 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) (We) (did) (did not) view the body after death.           |                  |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                     |  |                                                                    |  |
| 23A. SIGNATURE<br>Surat Sinasa, M.D.                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                                             |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                                                                                                                                                                                                |  | 23B. DATE SIGNED<br>11/8/71                                                                                         |  |                                                                    |  |
| 23C. PHYSICIAN'S NAME (Type)<br>SURAT SINASA, M.D.                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                                             |  | 23D. ADDRESS<br>BALTIMORE CITY HOSP., BALTIMORE, MD<br>4940 Eastern Avenue                                                                                                                                                                                                                                                     |  |                                                                                                                     |  |                                                                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                    |                  | 24B. DATE<br>11-12-71                                                                                                                                       |  | 24C. NAME of CEMETERY or CREMATORY<br>ARABUS MEM. PARK                                                                                                                                                                                                                                                                         |  | 24D. LOCATION (City, town, or county) (State)<br>BALTO. MD.                                                         |  |                                                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 10 1971                                                                                                                                                                                                                                                                                        |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, M.D.                                                                                                            |  | 25C. FUNERAL DIRECTOR V. BAILEY<br>KEELSON F. H., 1348 CALHOUN ST.                                                                                                                                                                                                                                                             |  |                                                                                                                     |  |                                                                    |  |





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

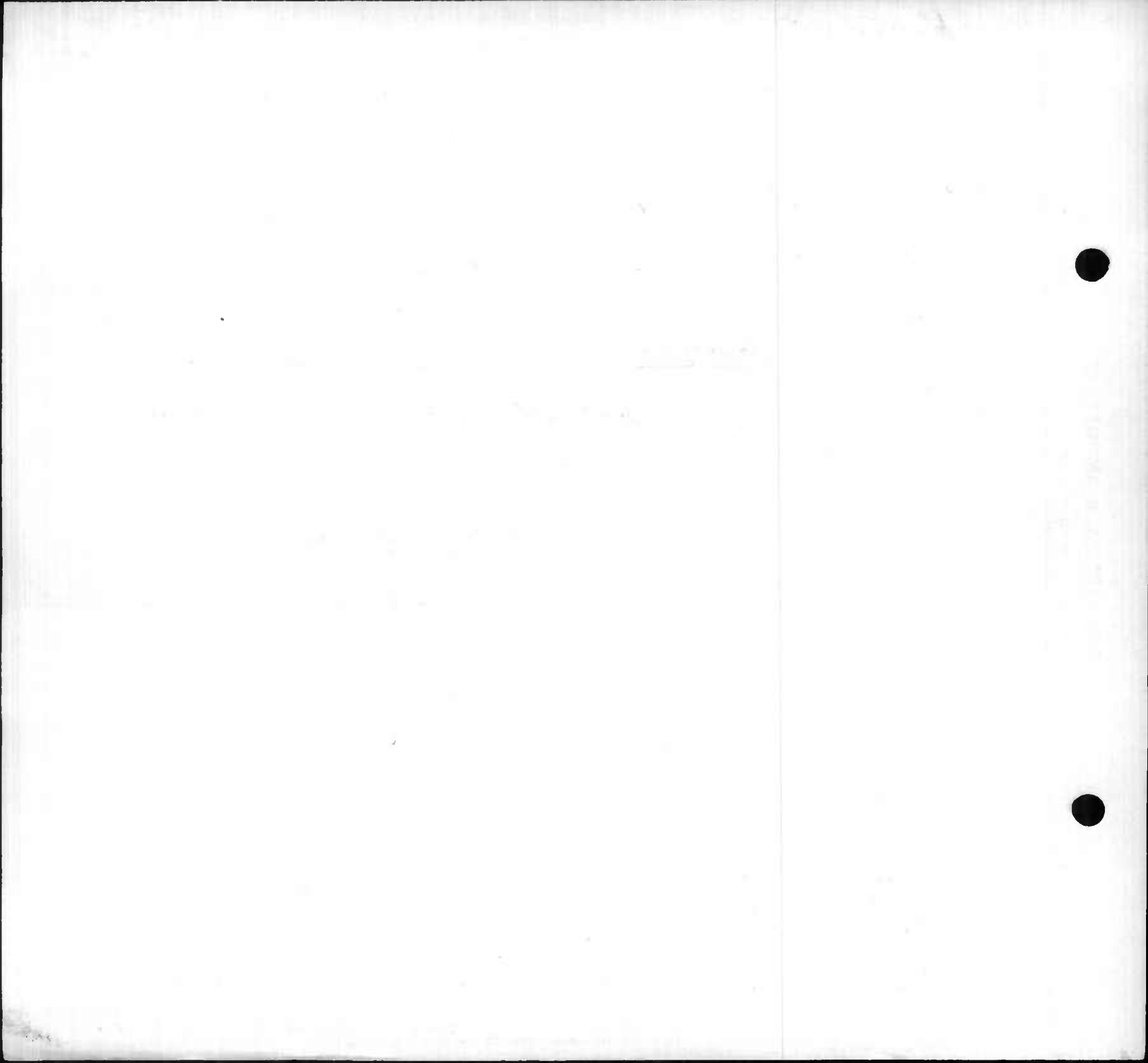
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                               |                                | REG. NO. 71 10374                                                                                                                                                                                                                                                                                                                                                |                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                           |                                |                                                                                                                                                                                                                                                                                                                                                                  |                                                |
| <b>R-212 71 10374</b><br><b>BIRTH NO.</b><br><b>1. NAME OF DECEASED (Type or Print)</b><br><b>ALBERT ROSSBACK</b>                                                                                                                                                                                                                                                              |                                | <b>2. DATE AND HOUR OF DEATH</b><br><b>November 8, 1971 10:43 P.</b>                                                                                                                                                                                                                                                                                             |                                                |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><b>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b><br><b>31 Baltimore City Hospital</b>                                                                                                                                                         |                                | <b>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</b><br><b>A. STATE B. COUNTY</b><br><b>Maryland BALTO 5300</b><br><b>C. CITY OR TOWN D. INSIDE CITY LIMITS?</b><br><b>Baltimore YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b><br><b>E. STREET AND NUMBER</b><br><b>2414 Plainfield Avenue</b> |                                                |
| <b>5. SEX</b><br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                   | <b>6. RACE</b><br><b>White</b> | <b>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></b><br><b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>                                                                                                                                                                                        | <b>8. DATE OF BIRTH</b><br><b>May 17, 1907</b> |
| <b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b><br><b>Retired</b>                                                                                                                                                                                                                                                           |                                | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><b>Electrical Supervisor</b>                                                                                                                                                                                                                                                                                         |                                                |
| <b>11. BIRTHPLACE (State or foreign country)</b><br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                        |                                | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                             |                                                |
| <b>13. FATHER'S NAME</b><br><b>Albert Rossback</b>                                                                                                                                                                                                                                                                                                                             |                                | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Daisy Swab</b>                                                                                                                                                                                                                                                                                                             |                                                |
| <b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b>                                                                                                                                                                                                                                                                |                                | <b>16. SOCIAL SECURITY NO.</b><br><b>212-01-9227</b>                                                                                                                                                                                                                                                                                                             |                                                |
| <b>17. INFORMANT</b><br><b>Mrs Elizabeth Rossback</b>                                                                                                                                                                                                                                                                                                                          |                                | <b>ADDRESS</b><br><b>2414 Plainfield Ave.</b>                                                                                                                                                                                                                                                                                                                    |                                                |
| <b>18. CAUSE OF DEATH</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br><small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small><br><b>410.9 I</b><br><b>Anterior Occlusion</b><br><b>Anteriosclerotic Heart Disease</b><br><b>UNDERLYING CONDITION last,</b> |                                | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><b>Immediate</b><br><b>2 years</b>                                                                                                                                                                                                                                                                        |                                                |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>                                                                                                                                                                                                                           |                                |                                                                                                                                                                                                                                                                                                                                                                  |                                                |
| <b>19A. DATE OF OPERATION</b><br><b>0</b>                                                                                                                                                                                                                                                                                                                                      |                                | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br><b>No</b>                                                                                                                                                                                                                                                                                             |                                                |
| <b>20A. AUTOPSY? (Yes or No)</b><br><b>No</b>                                                                                                                                                                                                                                                                                                                                  |                                | <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>                                                                                                                                                                                                                                                                                      |                                                |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b><br><input type="checkbox"/>                                                                                                                                                                                                                                                       |                                | <b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b>                                                                                                                                                                                                                                                                  |                                                |
| <b>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</b>                                                                                                                                                                                                                                                                                                |                                | <b>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>                                                                                                                                                                                                                                                                                                           |                                                |
| <b>21E. INJURY OCCURRED</b><br><b>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></b>                                                                                                                                                                                                                                                        |                                | <b>21F. HOW DID INJURY OCCUR?</b>                                                                                                                                                                                                                                                                                                                                |                                                |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>Oct. 19 70</b> <b>to</b> <b>11/8 19 71</b><br><b>that (I) (we) last saw the deceased alive on</b> <b>11/5 19 71</b> <b>and that (in my) (our) opinion death occurred on the date</b><br><b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>      |                                |                                                                                                                                                                                                                                                                                                                                                                  |                                                |
| <b>23A. SIGNATURE</b><br><b>Joseph S. Cameron</b>                                                                                                                                                                                                                                                                                                                              |                                | <b>23B. DATE SIGNED</b><br><b>11/10/71</b>                                                                                                                                                                                                                                                                                                                       |                                                |
| <b>23C. PHYSICIAN'S NAME (Type)</b><br><b>JOSEPH S. CAMERON</b>                                                                                                                                                                                                                                                                                                                |                                | <b>23D. ADDRESS</b><br><b>1012 Old North Pt Rd - BALTO, MD</b>                                                                                                                                                                                                                                                                                                   |                                                |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>                                                                                                                                                                                                                                                                                                               |                                | <b>24B. DATE</b><br><b>11-12-1971</b>                                                                                                                                                                                                                                                                                                                            |                                                |
| <b>24C. NAME OF CEMETERY OR CREMATORY</b><br><b>Gardens of Faith</b>                                                                                                                                                                                                                                                                                                           |                                | <b>24D. LOCATION (City, town, or county) (State)</b><br><b>Baltimore County, Maryland</b>                                                                                                                                                                                                                                                                        |                                                |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><b>NOV 10 1971</b>                                                                                                                                                                                                                                                                                                                   |                                | <b>25B. NAME OF REGISTRAR</b><br><b>Robert E. Fisher, M.D.</b>                                                                                                                                                                                                                                                                                                   |                                                |
| <b>25C. FUNERAL DIRECTOR</b><br><b>Lilly &amp; Zeiler Inc.</b>                                                                                                                                                                                                                                                                                                                 |                                | <b>ADDRESS</b><br><b>1901-07 Eastern Ave.</b>                                                                                                                                                                                                                                                                                                                    |                                                |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

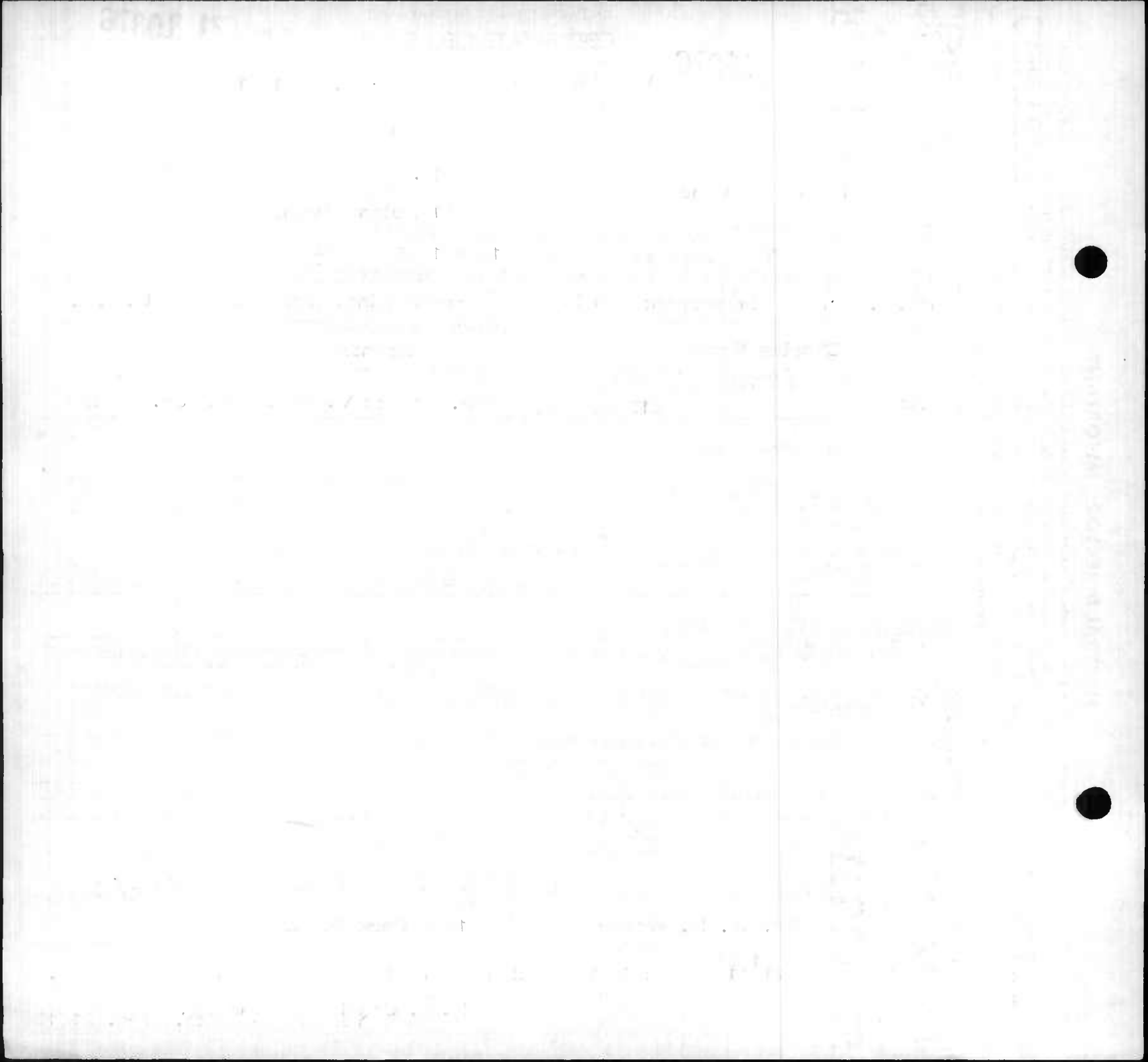
|                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                             |                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                  |                                                                                                        | 71 10375                                                                                                                                                    |                                                                          |
| 165671 10375                                                                                                                                                                                                                                                                                                      |                                                                                                        | REG. NO. 71 10375                                                                                                                                           |                                                                          |
| BIRTH NO.                                                                                                                                                                                                                                                                                                         |                                                                                                        | 2. DATE AND HOUR OF DEATH                                                                                                                                   |                                                                          |
| 1. NAME OF DECEASED<br>(Type or Print) <b>GRANVILLE GARNER</b>                                                                                                                                                                                                                                                    |                                                                                                        | 11/8/71 12:40PM                                                                                                                                             |                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                            |                                                                                                        | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                       |                                                                          |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>UNIVERSITY HOSPITAL<br/>LOMBARD + GREEN STREETS<br/>BALTIMORE, MD.</b>                                                                                                                            |                                                                                                        | A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b> <span style="float: right;">1304</span>                                                                         |                                                                          |
|                                                                                                                                                                                                                                                                                                                   |                                                                                                        | C. CITY OR TOWN <b>BALTO. MD.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                |                                                                          |
|                                                                                                                                                                                                                                                                                                                   |                                                                                                        | E. STREET AND NUMBER <b>3308 ARCHBISHOP TERRY.</b>                                                                                                          |                                                                          |
| 5. SEX <b>M</b>                                                                                                                                                                                                                                                                                                   | 6. RACE <b>NEGRO</b>                                                                                   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>12-12-05</b>                                         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CHAUFFEUR</b>                                                                                                                                                                                                   |                                                                                                        | 9. AGE (in years last birthday) <b>65</b>                                                                                                                   |                                                                          |
| 10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>                                                                                                                                                                                                                                                                        |                                                                                                        | 11. BIRTHPLACE (State or foreign country) <b>Virginia</b>                                                                                                   |                                                                          |
| 13. FATHER'S NAME <b>LEONARD GARNER</b>                                                                                                                                                                                                                                                                           |                                                                                                        | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                                  |                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                             |                                                                                                        | 14. MOTHER'S MAIDEN NAME <b>ADLENA JOHNSON</b>                                                                                                              |                                                                          |
| 16. SOCIAL SECURITY NO. <b>212-18-7088</b>                                                                                                                                                                                                                                                                        |                                                                                                        | 17. INFORMANT <b>Ora E. Graves - 802 N. Mount St.</b>                                                                                                       |                                                                          |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>HYPOXEMIA</b>                                                                                                                                                                                                                                            |                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |                                                                          |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                      |                                                                                                        |                                                                                                                                                             |                                                                          |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                 |                                                                                                        | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                      |                                                                          |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                         |                                                                                                        | (B) <b>SMALL CELL CARCINOMA OF LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                  |                                                                          |
|                                                                                                                                                                                                                                                                                                                   |                                                                                                        | (C) _____                                                                                                                                                   |                                                                          |
| II                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                             |                                                                          |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                             |                                                                          |
| 19A. DATE OF OPERATION <b>0</b>                                                                                                                                                                                                                                                                                   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       | 20A. AUTOPSY? (Yes or No) <b>No</b>                                                                                                                         | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |                                                                          |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |                                                                          |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                             |                                                                          |
| 23A. SIGNATURE <b>Stephen Greenberg</b>                                                                                                                                                                                                                                                                           |                                                                                                        | 23B. DATE SIGNED <b>11/8/71</b>                                                                                                                             |                                                                          |
| 23C. PHYSICIAN'S NAME (Type) <b>Stephen Greenberg MD</b>                                                                                                                                                                                                                                                          |                                                                                                        | 23D. ADDRESS                                                                                                                                                |                                                                          |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                            | 24B. DATE <b>11-12-71</b>                                                                              | 24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>                                                                                             | 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b> |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 10 1971</b>                                                                                                                                                                                                                                                                | 25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>                                                   | 25C. FUNERAL DIRECTOR <b>Mary-Elizabeth Law</b> ADDRESS <b>802 Madison Ave.</b>                                                                             |                                                                          |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                   |                                                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | REG. NO. <span style="font-size: 1.2em;">71 10376</span>                                                                             |                                                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| BIRTH NO. <span style="font-size: 1.2em;">71 10376</span>                                                                                                                                                                                                                                                                                                                                                                          |                                                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CERTIFICATE OF DEATH                                                                                                                 |                                                                                                          |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">Eleanor Reeve Patterson</span>                                                                                                                                                                                                                                                                                                                              |                                                     |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.2em;">Nov. 8, 1971</span> <span style="float: right;"><span style="font-size: 1.2em;">7:30 P.M.</span></span>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                      |                                                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                             |                                                     |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)<br>A. STATE <span style="font-size: 1.2em;">Maryland</span><br>B. COUNTY <span style="font-size: 1.2em;">2713</span>                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                      |                                                                                                          |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br><span style="font-size: 1.2em;">00 5801 Roland Avenue</span>                                                                                                                                                                                                                                                                                                                           |                                                     |                                                                                                                                                             | C. CITY OR TOWN<br><span style="font-size: 1.2em;">Balto.</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                      | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> * NO <input type="checkbox"/>                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                     |                                                                                                                                                             | E. STREET AND NUMBER<br><span style="font-size: 1.2em;">5801 Roland Avenue</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                      |                                                                                                          |
| 5. SEX<br><span style="font-size: 1.2em;">F</span>                                                                                                                                                                                                                                                                                                                                                                                 | 6. RACE<br><span style="font-size: 1.2em;">W</span> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><span style="font-size: 1.2em;">10-5-1895</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 9. AGE (In years last birthday)<br><span style="font-size: 1.2em;">76</span>                                                         | 10. Under 1 Yr. Months Days<br>11. Under 24 Hrs. Hours Min.                                              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">Ret'd. Banker. Investment Banking</span>                                                                                                                                                                                                                                                            |                                                     |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                      | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">Brandywine, Maryland</span> |
| 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">U.S.A.</span>                                                                                                                                                                                                                                                                                                                                                      |                                                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                      |                                                                                                          |
| 13. FATHER'S NAME<br><span style="font-size: 1.2em;">Charles Reeve</span>                                                                                                                                                                                                                                                                                                                                                          |                                                     |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">Eleanor</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                      |                                                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">No</span>                                                                                                                                                                                                                                                                              |                                                     |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.2em;">2 7-34-3825</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                      | 17. INFORMANT ADDRESS<br><span style="font-size: 1.2em;">Mr. Robert U. Patterson, Jr. Same</span>        |
| 18. <span style="font-size: 1.2em;">410.9 I</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                         |                                                     |                                                                                                                                                             | CAUSE OF DEATH<br><span style="font-size: 1.2em;">Coronary Occlusion</span><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF<br><span style="font-size: 1.2em;">Coronary Vascular Dis., Parkinson disease</span><br>(B) DUE TO, OR AS A CONSEQUENCE OF<br><span style="font-size: 1.2em;">Perforation to sigmoides cutaneous</span><br>(C) <span style="font-size: 1.2em;">not given by Dr. Russell Lewis M.D.</span><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><span style="font-size: 1.2em;">30 minutes</span><br><span style="font-size: 1.2em;">Cholesterol 4-5 yrs.</span> |                                                                                                                                      |                                                                                                          |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                             |                                                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                      |                                                                                                          |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.2em;">0</span>                                                                                                                                                                                                                                                                                                                                                                 |                                                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20A. AUTOPSY (Yes or No)<br><span style="font-size: 1.2em;">No</span>                                                                |                                                                                                          |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                               |                                                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                      |                                                                                                          |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                              |                                                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                             |                                                                                                          |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                          |                                                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 21F. HOW DID INJURY OCCUR?                                                                                                           |                                                                                                          |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">Oct 4 1970</span> 19 to <span style="font-size: 1.2em;">Nov 8 1971</span> that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">July 1971</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                      |                                                                                                          |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">W.H. Woody</span> <span style="float: right;"><span style="font-size: 1.2em;">M.D.</span></span>                                                                                                                                                                                                                                                                                 |                                                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">11/6/71</span>                                                                   |                                                                                                          |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">Dr. W. H. Woody</span>                                                                                                                                                                                                                                                                                                                                             |                                                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 23D. ADDRESS<br><span style="font-size: 1.2em;">1403 Park Avenue</span>                                                              |                                                                                                          |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">Burial</span>                                                                                                                                                                                                                                                                                                                                          |                                                     | 24B. DATE<br><span style="font-size: 1.2em;">1971 11-11-</span>                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 24C. NAME OF CEMETERY OR CREMATORY<br><span style="font-size: 1.2em;">Arlington National Cemetery</span>                             |                                                                                                          |
| 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">Arlington, Pa.</span>                                                                                                                                                                                                                                                                                                                             |                                                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                      |                                                                                                          |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.2em;">NOV 10 1971</span>                                                                                                                                                                                                                                                                                                                                              |                                                     | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 25C. FUNERAL DIRECTOR ADDRESS<br><span style="font-size: 1.2em;">H.W. Jenkins &amp; Sons Co. 4905 York Road Balto., Md. 21212</span> |                                                                                                          |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-356                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                                                   | CITY HEALTH DEPARTMENT                                                                                                                                          |                                                              | REG. NO. 71 10377                                                                             |                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------------|
| BIRTH NO. 71 10377                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                                                   | CERTIFICATE OF DEATH                                                                                                                                            |                                                              |                                                                                               |                                             |
| 1. NAME OF DECEASED<br>(Type or Print) <b>JAMES W. BITTNER</b>                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                                                   | 2. DATE AND HOUR OF DEATH<br><b>11/8/71 4:27 PM.</b>                                                                                                            |                                                              |                                                                                               |                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                                                   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                           |                                                              |                                                                                               |                                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                                                   | A. STATE<br><b>MARYLAND</b>                                                                                                                                     |                                                              | B. COUNTY<br><b>BALTO</b>                                                                     |                                             |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                                   | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                             |                                                              | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                             |
|                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                                                   | E. STREET AND NUMBER<br><b>7001 N. CHARLES ST.</b>                                                                                                              |                                                              |                                                                                               |                                             |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                            | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1/6/1882</b>                               | 9. AGE (In years last birthday)<br><b>89</b>                                                                                                                    | If Under 1 Yr. Months: Days: Hours: Min.                     | If Under 24 Hrs. Hours: Min.                                                                  |                                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED CLASS. SUPT. CO.</b>                                                                                                                                                                                                   |                         |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>ARMOUR FERTILIZER CO.</b> |                                                                                                                                                                 | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b> |                                                                                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b> |
| 13. FATHER'S NAME<br><b>RICHARD BITTNER</b>                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |                                                                   | 14. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>                                                                                                                      |                                                              |                                                                                               |                                             |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                            |                         | 16. SOCIAL SECURITY NO.<br><b>215-05-5372A</b>                                                                                                              |                                                                   | 17. INFORMANT<br><b>MRS. MARY ANN BITTNER (SAME)</b>                                                                                                            |                                                              | ADDRESS                                                                                       |                                             |
| 18. <b>1990 I</b>                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                                                   | CAUSE OF DEATH                                                                                                                                                  |                                                              |                                                                                               |                                             |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                   |                         |                                                                                                                                                             |                                                                   | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIO RESPIRATORY FAILURE</b>                                                                        |                                                              |                                                                                               |                                             |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                                                   | (B) <b>METASTATIC CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                              |                                                              |                                                                                               |                                             |
|                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                                                   | (C)                                                                                                                                                             |                                                              |                                                                                               |                                             |
| II                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                                                   | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>DEHYDRATION. UREMIA.</b> |                                                              |                                                                                               |                                             |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                               |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                   | 20A. AUTOPSY (Yes or No)<br><b>No</b>                                                                                                                           |                                                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH                           |                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                            |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                        |                                                              |                                                                                               |                                             |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                        |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                   | 21F. HOW DID INJURY OCCUR?                                                                                                                                      |                                                              |                                                                                               |                                             |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11/4/71</b> 19 to <b>11/8/71</b> 19 that (I) (we) last saw the deceased alive on <b>11/8/71</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                                                   |                                                                                                                                                                 |                                                              |                                                                                               |                                             |
| 23A. SIGNATURE<br><b>Del Busto MD</b>                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                                                   | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                                 |                                                              | 23B. DATE SIGNED<br><b>11/8/71</b>                                                            |                                             |
| 23C. PHYSICIAN'S NAME (Type)<br><b>DAVID DEL BUSTO MD</b>                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                                                   | 23D. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                                                  |                                                              |                                                                                               |                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                        |                         | 24B. DATE<br><b>11-11-71</b>                                                                                                                                |                                                                   | 24C. NAME of CEMETERY or CREMATORY<br><b>Holy Redeemer Cemetery</b>                                                                                             |                                                              | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>                            |                                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 10 1971</b>                                                                                                                                                                                                                                                                            |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>                                                                                                     |                                                                   | 25C. FUNERAL DIRECTOR<br><b>H. W. Jenkins &amp; Sons Co.,</b>                                                                                                   |                                                              | ADDRESS<br><b>4905 York Road Balto., Md. 21212</b>                                            |                                             |

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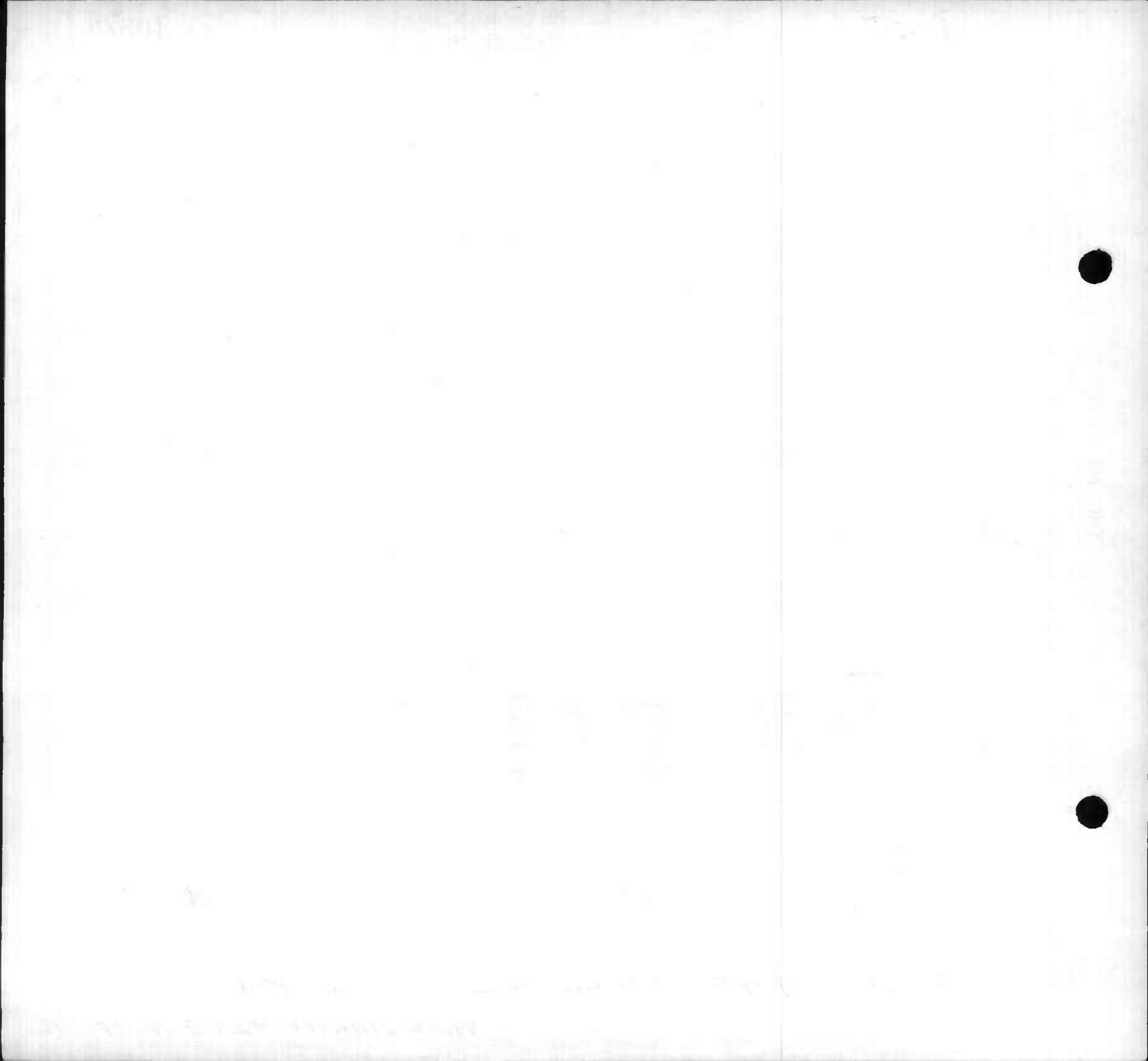
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

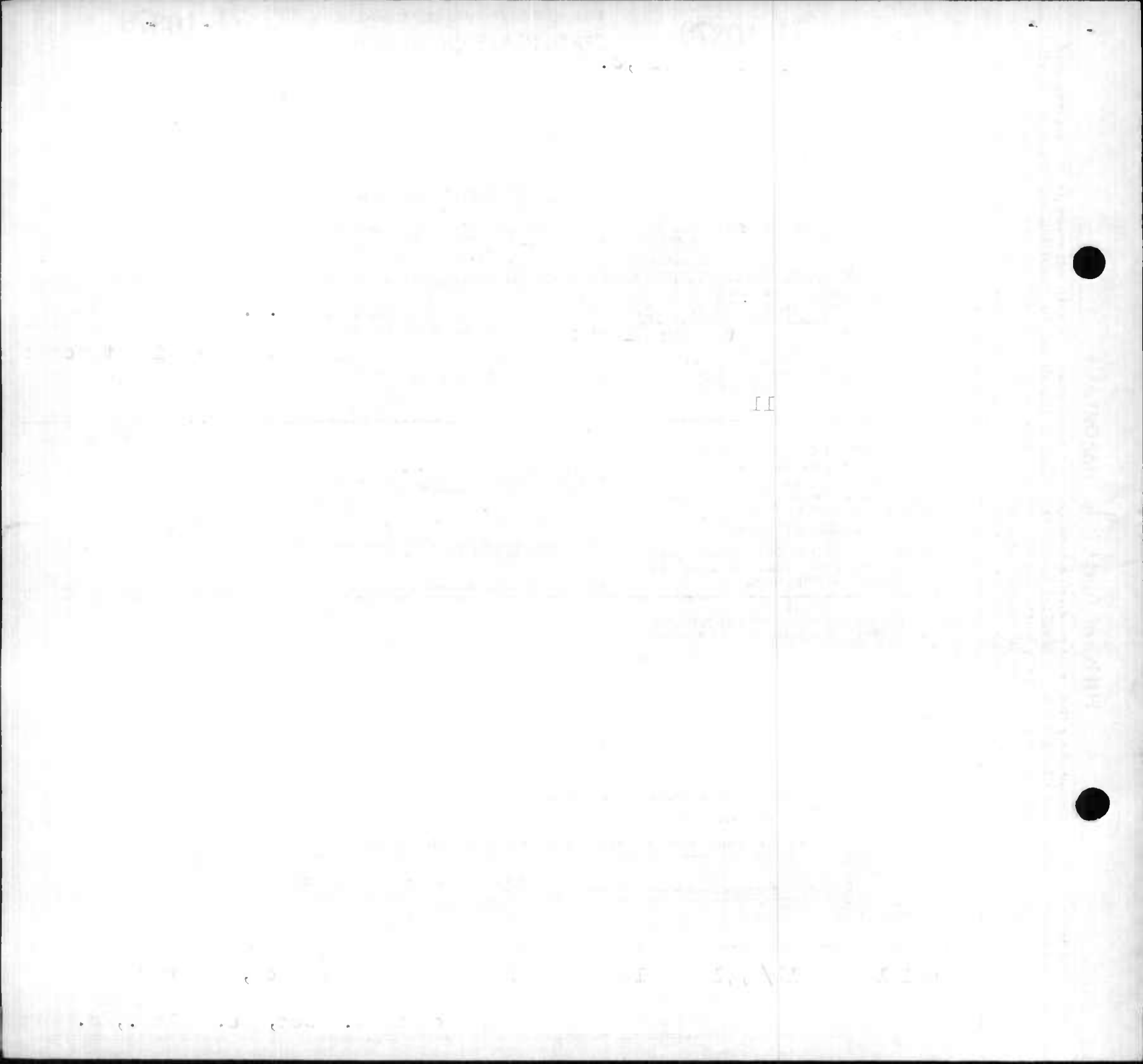
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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------|
| D-650 71 10378                                                                                                                                                                                                                                                                                                                                                                                                                              |                         | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                 |                                                                                                                                                                                                                                                                                                                    | 71 10378                                                                             |                                                               |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | CERTIFICATE OF DEATH                                                                                                                             |                                                                                                                                                                                                                                                                                                                    | REG. NO.                                                                             |                                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ERNEST B. DURHAM</b>                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                  | 2. DATE AND HOUR OF DEATH<br><b>NOV 9, 1971 11:00 P.M.</b>                                                                                                                                                                                                                                                         |                                                                                      |                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>49 NORTH CHARLES GEN HOSP</b>                                                                                                                                                                                                                                 |                         |                                                                                                                                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>908</b><br>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>2235 COOL AVE</b> |                                                                                      |                                                               |
| 5. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                          | 6. RACE<br><b>NEGRO</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11/1/04</b>                                                                                                                                                                                                                                                                                 | 9. AGE (In years last birthday)<br><b>67</b>                                         | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min.     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER</b>                                                                                                                                                                                                                                                                                                                               |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                                                                                                    |                                                                                                                                                                                                                                                                                                                    | 11. BIRTHPLACE (State or foreign country)<br><b>NORTH CAROLINA</b>                   |                                                               |
| 13. FATHER'S NAME<br><b>JAMES DURHAM</b>                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                         |                                                                                      |                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>-</b>                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                  | 14. MOTHER'S MAIDEN NAME<br><b>MAGGIE GREEN</b>                                                                                                                                                                                                                                                                    |                                                                                      | 16. SOCIAL SECURITY NO.<br><b>218-22-7631</b>                 |
| 18. <b>16211 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>PLEURAL EFFUSION - METASTASIS - DISSEMINATED</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>ADENOCARCINOMA LUNG</b> |                         |                                                                                                                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>WEEKS - MONTHS</b>                                                                                                                                                                                                                                              |                                                                                      |                                                               |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                    |                                                                                      |                                                               |
| 19A. DATE OF OPERATION<br><b>NOV 27, 1971</b>                                                                                                                                                                                                                                                                                                                                                                                               |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CA of lung - bronchogenic</b>                                                             |                                                                                                                                                                                                                                                                                                                    | 20A. AUTOPSY? (Yes or No)<br><b>-</b>                                                |                                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                           |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>-</b>                                             |                                                                                                                                                                                                                                                                                                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>-</b> |                                                               |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br><b>-</b>                                                                                                                                                                                                                                                                                                                                                                    |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                        |                                                                                                                                                                                                                                                                                                                    | 21F. HOW DID INJURY OCCUR?<br><b>-</b>                                               |                                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/27</b> 19 <b>71</b> to <b>Nov 9</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>Nov 9</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                    |                         |                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                    |                                                                                      |                                                               |
| 23A. SIGNATURE<br><b>B. C. VENERACION JR MD</b>                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                  | 23B. DATE SIGNED<br><b>11/19/71</b>                                                                                                                                                                                                                                                                                |                                                                                      | 23C. PHYSICIAN'S NAME (Type)<br><b>B. C. VENERACION JR MD</b> |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                  | 24B. DATE<br><b>11/15/71</b>                                                                                                                                                                                                                                                                                       |                                                                                      | 24C. NAME of CEMETERY or CREMATORY<br><b>Mt. Auburn Cem</b>   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 10 1971</b>                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                  | 25B. NAME OF REGISTRAR<br><b>-</b>                                                                                                                                                                                                                                                                                 |                                                                                      | 25C. FUNERAL DIRECTOR<br><b>Wm C MARCH</b>                    |
| 25D. ADDRESS<br><b>928 E NORTH Ave</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                  | 25E. ADDRESS<br><b>-</b>                                                                                                                                                                                                                                                                                           |                                                                                      |                                                               |



# FUNERAL DIRECTOR: IMPORTANT

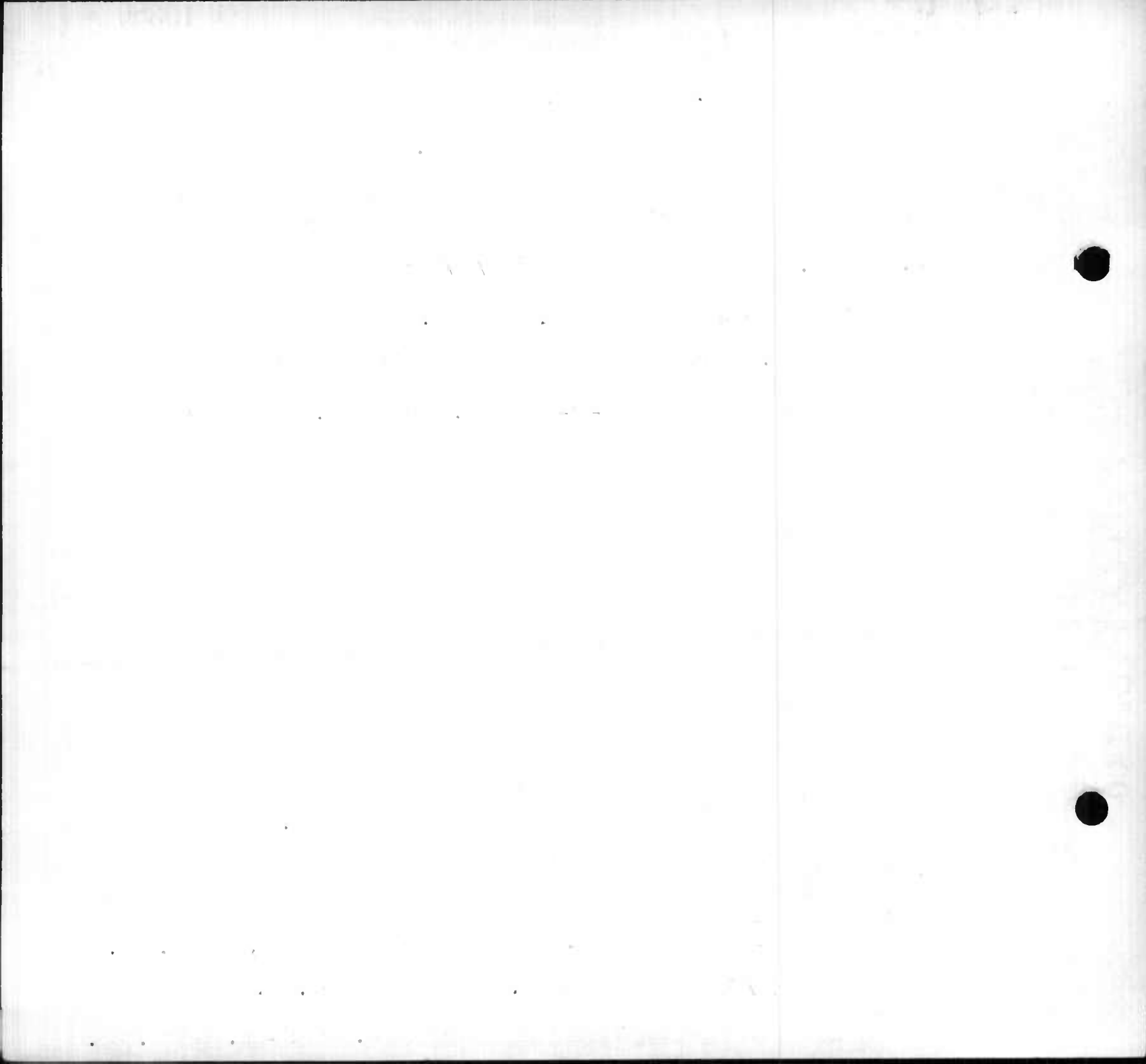
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                |  | REG. NO. <b>71-10379</b>                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| K-220 71 10379<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                |  |                                                                          |  |
| BIRTH NO. <b>71 10379</b>                                                                                                                                                                                                                                                                                                                              |  | 1. NAME OF DECEASED <b>KISAK FRANCIS, J.</b><br>(Type or Print) <b>KISAK FRANCIS</b>                                                           |  |                                                                          |  |
| 2. DATE AND HOUR OF DEATH<br><b>Nov. 4, 1971 134 20' a.m.</b>                                                                                                                                                                                                                                                                                          |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>UNION MEMORIAL HOSPITAL</b>                                                       |  |                                                                          |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>                                                                                                                                                                                                           |  | 5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>UNION MEMORIAL HOSPITAL</b> |  |                                                                          |  |
| C. CITY OR TOWN <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                       |  | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                     |  |                                                                          |  |
| E. STREET AND NUMBER <b>6205 RIDGEVIEW ROAD BALTO 06</b>                                                                                                                                                                                                                                                                                               |  | 6. SEX <b>M</b> 7. RACE <b>W</b> 8. DATE OF BIRTH <b>05-26-18</b> 9. AGE (In years last birthday) <b>53</b>                                    |  |                                                                          |  |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>                                                                                                                                                                                                                                            |  | 10B. KIND OF BUSINESS OR INDUSTRY <b>MARTIN CO.</b>                                                                                            |  | 11. BIRTHPLACE (State or foreign country) <b>U.S.S.R. N.Y.</b>           |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>                                                                                                                                                                                                                                                                                                           |  | 13. FATHER'S NAME <b>Stephen Kissak</b>                                                                                                        |  | 14. MOTHER'S MAIDEN NAME <b>Sophie Stanczak</b>                          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>WW II</b>                                                                                                                                                                                                                                  |  | 16. SOCIAL SECURITY NO.                                                                                                                        |  | 17. INFORMANT <b>CHART</b>                                               |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                |  |                                                                          |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                         |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF: <b>hepatic encephalopathy and GI bleeding</b>                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>              |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                         |  | (B) <b>unknown etiology</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                 |  |                                                                          |  |
| (C)                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                |  |                                                                          |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                 |  |                                                                                                                                                |  |                                                                          |  |
| 19A. DATE OF OPERATION <b>2</b>                                                                                                                                                                                                                                                                                                                        |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |  | 20A. AUTOPSY? (Yes or No) <b>yes</b>                                     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                       |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                              |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                      |  | 21F. HOW DID INJURY OCCUR?                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-28</b> 19 <b>71</b> to <b>11-4</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>11-4</b> 19 <b>71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                                |  |                                                                          |  |
| 23A. SIGNATURE <b>[Signature]</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                |  | 23B. DATE SIGNED <b>11-4-1971</b>                                        |  |
| 23C. PHYSICIAN'S NAME (Type) <b>[Signature]</b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                |  | 23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>                              |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                 |  | 24B. DATE <b>11/8/71</b>                                                                                                                       |  | 24C. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>               |  |
| 24D. LOCATION (City, town, or county) <b>Salamanca, New York</b>                                                                                                                                                                                                                                                                                       |  | 24E. LOCATION (State) <b>(State)</b>                                                                                                           |  |                                                                          |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 10 1971</b>                                                                                                                                                                                                                                                                                                     |  | 25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>                                                                                           |  | 25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto., Md.</b>           |  |



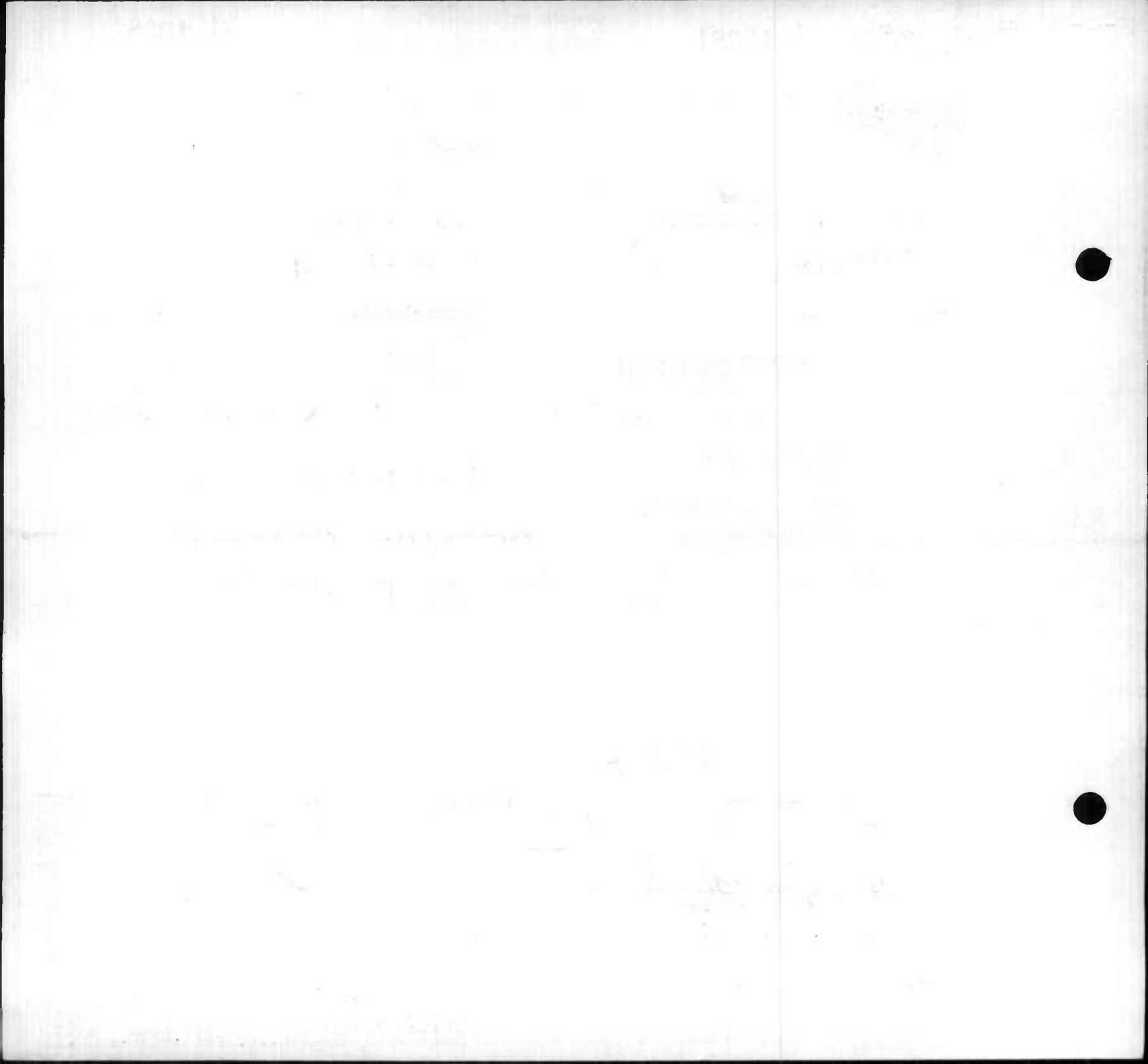
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.                                                                                                                                                                                                                                                                                                |               | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |                               | 71 10380                                                                                      |                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                   |               | 2. DATE AND HOUR OF DEATH                                                                                                                                   |                               | REG. NO.                                                                                      |                                                           |
| Conrad H. Hansen                                                                                                                                                                                                                                                                                         |               | 11/4/71                                                                                                                                                     |                               |                                                                                               |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                   |               | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                       |                               |                                                                                               |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>44 Union Memorial Hospital                                                                                                                                                                                                                                       |               | A. STATE: Md. 902                                                                                                                                           |                               |                                                                                               |                                                           |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                     |               | C. CITY OR TOWN<br>Baltimore                                                                                                                                |                               | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                           |
|                                                                                                                                                                                                                                                                                                          |               | E. STREET AND NUMBER<br>1528 Kennewick Road                                                                                                                 |                               |                                                                                               |                                                           |
| 5. SEX<br>M.                                                                                                                                                                                                                                                                                             | 6. RACE<br>W. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>9/24/1916 | 9. AGE (In years last birthday)<br>55                                                         | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Supply Officer Montebello State Hosp.                                                                                                                                                                     |               | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                               | 11. BIRTHPLACE (State or foreign country)<br>Md.                                              |                                                           |
| 13. FATHER'S NAME<br>Peter H. Hansen                                                                                                                                                                                                                                                                     |               | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                         |                               |                                                                                               |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>yes WW 2                                                                                                                                                                                     |               | 16. SOCIAL SECURITY NO.<br>213-07-3785                                                                                                                      |                               | 17. INFORMANT ADDRESS<br>Mrs. Catherine E. Hansen same                                        |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>410.017-23014 VENTRICULAR FIBRILLATION                                                             |               | CAUSE OF DEATH                                                                                                                                              |                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MINUTES                                       |                                                           |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                           |               | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>MYOCARDIAL INFARCTION ACUTE                                                                       |                               |                                                                                               |                                                           |
|                                                                                                                                                                                                                                                                                                          |               | (B) DUE TO, OR AS A CONSEQUENCE OF:<br>MYOCARDIAL INFARCTION - 9/10/71                                                                                      |                               |                                                                                               |                                                           |
|                                                                                                                                                                                                                                                                                                          |               | (C) DIABETES OBESITY HYPERTENSION CORONARY ARTERY SCLEROSIS                                                                                                 |                               |                                                                                               |                                                           |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                         |               |                                                                                                                                                             |                               |                                                                                               |                                                           |
| 19A. DATE OF OPERATION<br>O                                                                                                                                                                                                                                                                              |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                               | 20A. AUTOPSY? (Yes or No)<br>NO                                                               |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                           |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                           |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                |               | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                               | 21F. HOW DID INJURY OCCUR?                                                                    |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from 9/10 1971 to 11/4 1971 that (I) (we) last saw the deceased alive on 11/1 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |               |                                                                                                                                                             |                               |                                                                                               |                                                           |
| 23A. SIGNATURE<br>Frank Borges MD.                                                                                                                                                                                                                                                                       |               | 23B. DATE SIGNED<br>11/5/71                                                                                                                                 |                               | 23C. PHYSICIAN'S NAME (Type)<br>Frank Borges MD.                                              |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                       |               | 24B. DATE<br>11/8/71                                                                                                                                        |                               | 24C. NAME of CEMETERY or CREMATORY<br>Loudon Park Cem.                                        |                                                           |
| 24D. LOCATION (City, town, or county)<br>Balto. Md.                                                                                                                                                                                                                                                      |               | 24E. DATE REC'D BY HEALTH DEPT.<br>NOV 10 1971                                                                                                              |                               | 24F. NAME OF REGISTRAR<br>Leonard J. Ruck Inc. Balto. Md.                                     |                                                           |
| 24G. NAME OF REGISTRAR<br>Leonard J. Ruck Inc. Balto. Md.                                                                                                                                                                                                                                                |               | 24H. FUNERAL DIRECTOR<br>Leonard J. Ruck Inc. Balto. Md.                                                                                                    |                               | 24I. ADDRESS<br>Leonard J. Ruck Inc. Balto. Md.                                               |                                                           |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                                                                       |                                     |                                                                                                      |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|------------------------------------------------------------------------------------------------------|----------------------------------------------|
| K-450 71 10381                                                                                                                                                                                                                                                                                                                                                                                                |                         | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                              |                                     | REG. NO. 71 10381                                                                                    |                                              |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>KLINE, Robert Charles Jr.</b>                                                                                                                               |                                     | 2. DATE AND HOUR OF DEATH<br><b>2 Nov 71</b> <b>3</b> P.M.                                           |                                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                        |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Prince George's</b>                                                    |                                     | 6600                                                                                                 |                                              |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Hospital</b><br>4940 Eastern Avenue<br>Baltimore, Maryland 21224                                                                                                                                                                                                                                                                                    |                         | C. CITY OR TOWN<br><b>Adelphi</b>                                                                                                                                                                     |                                     | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |                                              |
| E. STREET AND NUMBER<br><b>10506 Edgfield Dr.</b>                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                                                                       |                                     |                                                                                                      |                                              |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                         | 6. RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                           | 8. DATE OF BIRTH<br><b>11-14-29</b> | 9. AGE (in years last birthday)<br><b>41</b>                                                         | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MACHINICIAN</b>                                                                                                                                                                                                                                                                                             |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                     |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>                                     |                                              |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                                                                       |                                     |                                                                                                      |                                              |
| 13. FATHER'S NAME<br><b>Robert Charles Kline</b>                                                                                                                                                                                                                                                                                                                                                              |                         | 14. MOTHER'S MAIDEN NAME<br><b>Ethel Kieffer</b>                                                                                                                                                      |                                     |                                                                                                      |                                              |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes</b>                                                                                                                                                                                                                                                                                        |                         | 16. SOCIAL SECURITY NO.<br><b>206-28-1115</b>                                                                                                                                                         |                                     | 17. INFORMANT<br>BCH RECORDS: <b>4940 Eastern Avenue</b><br><b>Baltimore, Maryland 21224</b>         |                                              |
| 18. CAUSE OF DEATH<br><b>204.01</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.                                       |                         | (A) IMMEDIATE CAUSE<br><b>KLEBSIELLA SEPTICEMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>KLEBSIELLA PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>ACUTE LYMPHOCYTIC LEUKEMIA</b> |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                         |                                              |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                                                                       |                                     |                                                                                                      |                                              |
| 19A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                            |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                      |                                     | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>                                                              |                                              |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                                                                       |                                     |                                                                                                      |                                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                         |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                              |                                     | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                          |                                              |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                             |                                     | 21F. HOW DID INJURY OCCUR?                                                                           |                                              |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>19 Oct</b> 19 <b>71</b> to <b>2 Nov</b> 19 <b>71</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>2 Nov</b> 19 <b>71</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death. |                         |                                                                                                                                                                                                       |                                     |                                                                                                      |                                              |
| 23A. SIGNATURE<br><b>Harvey M. GoComb M.D.</b>                                                                                                                                                                                                                                                                                                                                                                |                         | 23B. DATE SIGNED<br><b>2 Nov 71</b>                                                                                                                                                                   |                                     |                                                                                                      |                                              |
| 23C. PHYSICIAN'S NAME (Type)<br><b>HARVEY M. GO COMB M.D.</b>                                                                                                                                                                                                                                                                                                                                                 |                         | 23D. ADDRESS<br><b>4940 EASTERN AVE.</b>                                                                                                                                                              |                                     |                                                                                                      |                                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                     |                         | 24B. DATE<br><b>11-6-71</b>                                                                                                                                                                           |                                     | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park Cemetery</b>                                  |                                              |
| 24D. LOCATION<br><b>Bethlehem Northampton Penn.</b>                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                                                                       |                                     |                                                                                                      |                                              |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 10 1971</b>                                                                                                                                                                                                                                                                                                                                                         |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Bailey, R.D.</b>                                                                                                                                               |                                     | 25C. FUNERAL DIRECTOR<br><b>Francis J. Collins</b><br><b>500 University Blvd., W. Sil. Spr., Md.</b> |                                              |





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|
| <p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>                                                                                                                                                                                                                                                                              |  | <p>REG. NO. <u>71 10382</u></p>                                                                                                    |  |
| <p>BIRTH NO. <u>Robert Edward Lee Myers</u></p>                                                                                                                                                                                                                                                                                                                |  | <p>DATE AND HOUR OF DEATH <u>NOV. 8 1971 12:00 A.M.</u></p>                                                                        |  |
| <p>1. NAME OF DECEASED (Type or Print) <u>ROBERT MYERS</u></p>                                                                                                                                                                                                                                                                                                 |  | <p>2. DATE AND HOUR OF DEATH <u>NOV. 8 1971 12:00 A.M.</u></p>                                                                     |  |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>                                                                                                                                                                                                                                                                                                  |  | <p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</p>                                       |  |
| <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>SINAI HOSPITAL OF BALTO., INC.</u></p>                                                                                                                                                                                                  |  | <p>A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u></p>                                                                              |  |
| <p>5. SEX <u>M</u> 6. RACE <u>W</u></p>                                                                                                                                                                                                                                                                                                                        |  | <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> |  |
| <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>                                                                                                                                                                                                |  | <p>E. STREET AND NUMBER <u>3130 E. Joppa Road.</u></p>                                                                             |  |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>electrician</u></p>                                                                                                                                                                                                                                          |  | <p>8. DATE OF BIRTH <u>12-29-16</u> 9. AGE (in years last birthday) <u>54</u></p>                                                  |  |
| <p>10B. KIND OF BUSINESS OR INDUSTRY <u>American Totalizer</u></p>                                                                                                                                                                                                                                                                                             |  | <p>11. BIRTHPLACE (State or foreign country) <u>Maryland, USA</u></p>                                                              |  |
| <p>13. FATHER'S NAME <u>Levering Myers</u></p>                                                                                                                                                                                                                                                                                                                 |  | <p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>                                                                                     |  |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes WW 2</u></p>                                                                                                                                                                                                                                |  | <p>16. SOCIAL SECURITY NO. <u>219-01-1400</u></p>                                                                                  |  |
| <p>17. INFORMANT <u>wife</u> ADDRESS <u>same</u></p>                                                                                                                                                                                                                                                                                                           |  | <p>14. MOTHER'S MAIDEN NAME <u>Jessie Rippon</u></p>                                                                               |  |
| <p>18. CAUSE OF DEATH</p>                                                                                                                                                                                                                                                                                                                                      |  | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>                                                                                |  |
| <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>                                                                                                                                                      |  | <p>(A) IMMEDIATE CAUSE <u>Carcinomatous</u> <u>10-14-71</u></p>                                                                    |  |
| <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>                                                                                                                                                                                                                      |  | <p>(B) <u>Carcinoma of rectum</u> <u>6 months</u></p>                                                                              |  |
| <p>(C) _____</p>                                                                                                                                                                                                                                                                                                                                               |  | <p>(D) _____</p>                                                                                                                   |  |
| <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>                                                                                                                                                                                                                     |  |                                                                                                                                    |  |
| <p>19A. DATE OF OPERATION <u>0</u></p>                                                                                                                                                                                                                                                                                                                         |  | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____</p>                                                                      |  |
| <p>20A. AUTOPSY? (Yes or No) <u>NO</u></p>                                                                                                                                                                                                                                                                                                                     |  | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____</p>                                                  |  |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u></p>                                                                                                                                                                                                                                                         |  | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>                              |  |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____</p>                                                                                                                                                                                                                                                                          |  | <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) _____</p>                                                                       |  |
| <p>21E. INJURY OCCURRED _____</p>                                                                                                                                                                                                                                                                                                                              |  | <p>21F. HOW DID INJURY OCCUR? _____</p>                                                                                            |  |
| <p>22. I certify that (I) (this hospital) attended the deceased from <u>10-14</u> 19 <u>71</u> to <u>11-8</u> 19 <u>71</u> and that (I) (we) lost saw the deceased alive on <u>11-8</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> |  |                                                                                                                                    |  |
| <p>23A. SIGNATURE <u>David Zertung</u> MD DEGREE</p>                                                                                                                                                                                                                                                                                                           |  | <p>23B. DATE SIGNED <u>11-8-71</u></p>                                                                                             |  |
| <p>23C. PHYSICIAN'S NAME (Type) <u>DAVID ZERTUNG</u> MD DEGREE</p>                                                                                                                                                                                                                                                                                             |  | <p>23D. ADDRESS <u>5616 Park Heights Ave, Baltimore 21205</u></p>                                                                  |  |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>                                                                                                                                                                                                                                                                                                  |  | <p>24B. DATE <u>11/11/71</u></p>                                                                                                   |  |
| <p>24C. NAME of CEMETERY or CREMATORY <u>Cedar Hill Cem.</u></p>                                                                                                                                                                                                                                                                                               |  | <p>24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u></p>                                                             |  |
| <p>25A. DATE REC'D BY HEALTH DEPT. <u>NOV 10 1971</u></p>                                                                                                                                                                                                                                                                                                      |  | <p>25B. NAME OF REGISTRAR <u>Leonard J. Oruck Inc.</u></p>                                                                         |  |
| <p>25C. FUNERAL DIRECTOR <u>Leonard J. Oruck Inc.</u></p>                                                                                                                                                                                                                                                                                                      |  | <p>ADDRESS <u>Balto. Md.</u></p>                                                                                                   |  |

See also 10 31

See also 10 31

See also 10 31

See also 10 31

See also 10 31

See also 10 31

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                        |              |                                                                                                                                                                                                                                                                                                         |                               |                                                                                                           |                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| M-600 71 10383                                                                                                                                                                                                                                                                                                                                         |              | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                |                               | REG. NO. 71 10383                                                                                         |                                                          |
| BIRTH NO. Lee                                                                                                                                                                                                                                                                                                                                          |              | 1. NAME OF DECEASED<br>(Type or Print) MINNIE MOORE                                                                                                                                                                                                                                                     |                               | 2. DATE AND HOUR OF DEATH<br>11/14/71 11 A.M.                                                             |                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br>70 Century Nursing Home                                                                                                                                                                                                                          |              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md.<br>B. COUNTY 401                                                                                                                                                                                  |                               | C. CITY OR TOWN<br>Baltimore                                                                              |                                                          |
| D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                          |              | E. STREET AND NUMBER<br>102 N. Paca St.                                                                                                                                                                                                                                                                 |                               |                                                                                                           |                                                          |
| 5. SEX<br>F.                                                                                                                                                                                                                                                                                                                                           | 6. RACE<br>W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                             | 8. DATE OF BIRTH<br>6/15/1886 | 9. AGE (In years last birthday)<br>85                                                                     | 10. Under 1 Tr. Months; Days 11 Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife                                                                                                                                                                                                                                               |              | 10B. KIND OF BUSINESS OR INDUSTRY<br>Housewife                                                                                                                                                                                                                                                          |                               | 11. BIRTHPLACE (State or foreign country)<br>Va.                                                          |                                                          |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                    |              | 13. FATHER'S NAME<br>- Hodges                                                                                                                                                                                                                                                                           |                               | 14. MOTHER'S MAIDEN NAME<br>- Callie                                                                      |                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>no                                                                                                                                                                                                                                         |              | 16. SOCIAL SECURITY NO.<br>- -                                                                                                                                                                                                                                                                          |                               | 17. INFORMANT<br>Mrs Evelyn Carroll 6200 Elliott St #24                                                   |                                                          |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |              | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Cardiac Arrest<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>A.S. @ V. Disease<br>(C) Scurvy                                                                                                                                                      |                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Sudden                                                    |                                                          |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                 |              | Peripheral Vascular Disease                                                                                                                                                                                                                                                                             |                               |                                                                                                           |                                                          |
| 19A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                                            |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                        |                               | 20A. AUTOPSY? (Yes or No)                                                                                 |                                                          |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                   |              | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                       |                               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                                                          |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                               |              | 21D. TIME OF INJURY (APPROX.)<br>1 Month 1 Day (Year) 1 Hour                                                                                                                                                                                                                                            |                               | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                                          |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                             |              | 22. I certify that (I) (this hospital) attended the deceased from 11/1 to 11/14 1971<br>that (I) (we) lost saw the deceased alive on 11/1 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                               |                                                                                                           |                                                          |
| 23A. SIGNATURE<br>Joseph S. Blum M.D.                                                                                                                                                                                                                                                                                                                  |              | 23B. DATE SIGNED<br>11/15/71                                                                                                                                                                                                                                                                            |                               | 23C. PHYSICIAN'S NAME (Type)<br>JOSEPH S. BLUM M.D.                                                       |                                                          |
| 23D. ADDRESS<br>1115 N. CALVERT ST                                                                                                                                                                                                                                                                                                                     |              | 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                      |                               | 24B. DATE<br>Nov 9 '71                                                                                    |                                                          |
| 24C. NAME of CEMETERY or CREMATORY<br>Loudon Park Cemetery                                                                                                                                                                                                                                                                                             |              | 24D. LOCATION<br>(City, town, or county) Baltimore, Md.                                                                                                                                                                                                                                                 |                               | (State)                                                                                                   |                                                          |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 10 1971                                                                                                                                                                                                                                                                                                         |              | 25B. NAME OF REGISTRAR<br>John E. Taylor, R.S.                                                                                                                                                                                                                                                          |                               | 25C. FUNERAL DIRECTOR<br>Leonard J. Ruck, Inc. Baltimore, Md.                                             |                                                          |

7/1/65 - Adm.

Housewife

#24 Mrs Evelyn Carroll 6200 Elliott St

Burial Nov 9 '75 London Park Cemetery Baltimore, Md.

Leonard J. Ruck, Inc. Baltimore, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                           |                              |                                                                                                                                                             |                                                                                                                                                                                             | REG. NO. <b>71 10384</b>                                                                 |                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span><b>W-452 71 10384</b></span> </div>                                                                                                                                                                                                                                                                             |                              |                                                                                                                                                             |                                                                                                                                                                                             |                                                                                          |                                                                                               |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                          |                              | 1. NAME OF DECEASED<br>(Type or Print) <b>VINEY WILLIAMS</b>                                                                                                |                                                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>11-9-71 7:55</b> <span style="float: right;">A.M.</span> |                                                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>33 THE JOHNS HOPKINS HOSPITAL</b>                                                                                                                                                                    |                              |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY <b>1001</b>                                                       |                                                                                          |                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                    |                              |                                                                                                                                                             | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                                                         |                                                                                          | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                    |                              |                                                                                                                                                             | E. STREET AND NUMBER<br><b>1123 AISQUITTH ST.</b>                                                                                                                                           |                                                                                          |                                                                                               |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                            | 6. RACE<br><b>NEGRO</b>      | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/23/25</b>                                                                                                                                                         | 9. AGE (In years last birthday)<br><b>46</b>                                             | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Beautician</b>                                                                                                                                                                                                                                                                   |                              | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                                                                                                                                     |                                                                                          | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S. A.</b>                                                |
| 13. FATHER'S NAME<br><b>GEORGE HUGHES</b>                                                                                                                                                                                                                                                                                                                                          |                              |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>ADDIE ?</b>                                                                                                                                                  |                                                                                          |                                                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                              |                              | 16. SOCIAL SECURITY NO.<br><b>216-18-9872</b>                                                                                                               | 17. INFORMANT<br><b>Nola Hughes-1130 Harford Avenue</b>                                                                                                                                     |                                                                                          |                                                                                               |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                 |                              |                                                                                                                                                             |                                                                                                                                                                                             |                                                                                          |                                                                                               |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                               |                              |                                                                                                                                                             | (A) IMMEDIATE CAUSE <b>Hepatic and Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) <b>Chronic alcoholism, Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |                                                                                          |                                                                                               |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Profoundly coma</b><br><b>Many years</b><br><b>2 wk</b>                                                                                                                                                                                                                                                                         |                              |                                                                                                                                                             |                                                                                                                                                                                             |                                                                                          |                                                                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Sickle cell anemia</b>                                                                                                                                                                                                                |                              |                                                                                                                                                             |                                                                                                                                                                                             |                                                                                          |                                                                                               |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                             |                              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                             | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                   |                                                                                               |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                               |                              |                                                                                                                                                             |                                                                                                                                                                                             |                                                                                          |                                                                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                     |                              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                 |                                                                                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                          |                              | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                             | 21F. HOW DID INJURY OCCUR?                                                               |                                                                                               |
| 22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>10-21</b> 19 <b>71</b> to <b>11-9</b> 19 <b>71</b> that (I) <b>(we)</b> last saw the deceased alive on <b>11-9</b> 19 <b>71</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(we)</b> (did) (did not) view the body after death. |                              |                                                                                                                                                             |                                                                                                                                                                                             |                                                                                          |                                                                                               |
| 23A. SIGNATURE<br><b>John A. Nesbitt, III M.D.</b>                                                                                                                                                                                                                                                                                                                                 |                              |                                                                                                                                                             | 23B. DATE SIGNED<br><b>11-9-71</b>                                                                                                                                                          |                                                                                          |                                                                                               |
| 23C. PHYSICIAN'S NAME (Type)<br><b>JOHN A. NESBITT, III M.D.</b>                                                                                                                                                                                                                                                                                                                   |                              |                                                                                                                                                             | 23D. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL</b>                                                                                                                                           |                                                                                          |                                                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                          | 24B. DATE<br><b>11-12-71</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cemetery</b>                                                                                            |                                                                                                                                                                                             | 24D. LOCATION (City, town, or county) (State)<br><b>Streetport, Md.</b>                  |                                                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 10 1971</b>                                                                                                                                                                                                                                                                                                                              |                              | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>                                                                                                     |                                                                                                                                                                                             | 25C. FUNERAL DIRECTOR<br><b>ELLIETT Funeral Home 1129 N. Caroline St.</b>                |                                                                                               |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                    |                                        |                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                             |                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| <p><b>L-535</b>      <b>71 10385</b></p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;">REG. NO. <b>71 10385</b></p>                                                                                                                                                                              |                                        |                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                             |                                                                                                          |
| <p><b>BIRTH NO.</b> <span style="background-color: black; color: black;">[REDACTED]</span></p>                                                                                                                                                                                                                                                                                                                     |                                        | <p><b>1. NAME OF DECEASED</b><br/>(Type or Print) <b>LANTIN Y. KATHRYN M.</b></p>                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                  | <p><b>2. DATE AND HOUR OF DEATH</b><br/><b>11-8-71</b>      <b>3 P.M.</b></p>                               |                                                                                                          |
| <p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br/><b>LUTHERAN HOSPITAL</b><br/><b>730 ASH BURTON ST</b><br/><b>BALTIMORE MD 21216</b></p>                                                                                                                               |                                        |                                                                                                                                                                                          | <p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br/>A. STATE <b>MARYLAND</b>      B. COUNTY <b>1509</b></p> <p><b>C. CITY OR TOWN</b> <b>BALTIMORE</b>      <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p><b>E. STREET AND NUMBER</b><br/><b>3706 NORTONIA RD</b></p> |                                                                                                             |                                                                                                          |
| <p><b>5. SEX</b><br/><b>F</b></p>                                                                                                                                                                                                                                                                                                                                                                                  | <p><b>6. RACE</b><br/><b>WHITE</b></p> | <p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br/><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p> | <p><b>8. DATE OF BIRTH</b><br/><b>1-1-94</b></p>                                                                                                                                                                                                                                                                                                                                 | <p><b>9. AGE</b> (In years last birthday)<br/><b>77</b></p>                                                 | <p><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p> |
| <p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p>                                                                                                                                                                                                                                                                                                          |                                        | <p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p>                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                  | <p><b>11. BIRTHPLACE</b> (State or foreign country)<br/><b>Maryland</b></p>                                 |                                                                                                          |
| <p><b>13. FATHER'S NAME</b><br/><b>Joseph Dantoni</b></p>                                                                                                                                                                                                                                                                                                                                                          |                                        |                                                                                                                                                                                          | <p><b>14. MOTHER'S MAIDEN NAME</b><br/><b>Lucy Palagardo</b></p>                                                                                                                                                                                                                                                                                                                 |                                                                                                             |                                                                                                          |
| <p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p>                                                                                                                                                                                                                                                                                             |                                        | <p><b>16. SOCIAL SECURITY NO.</b><br/><b>215-12-3459</b></p>                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                  | <p><b>17. INFORMANT</b> <b>Catherine Rubin</b>      <b>ADDRESS</b> <b>5901 Cecil Avenue 21207</b></p>       |                                                                                                          |
| <p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br/>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br/><b>CAUSE OF DEATH</b><br/><b>(A) IMMEDIATE CAUSE</b> <b>Cardio Respiratory Failure</b><br/><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br/><b>(B) Fracture of the Hip</b><br/><b>(C) Diabetes</b></p> |                                        |                                                                                                                                                                                          | <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>                                                                                                                                                                                                                                                                                                                       |                                                                                                             |                                                                                                          |
| <p><b>II</b><br/><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>                                                                                                                                                                                                                                                       |                                        |                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                             |                                                                                                          |
| <p><b>19A. DATE OF OPERATION</b><br/><b>11-5-71</b></p>                                                                                                                                                                                                                                                                                                                                                            |                                        | <p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br/><b>S.P. N.A. Fracture Hip</b></p>                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                  | <p><b>20A. AUTOPSY?</b> (Yes or No) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> |                                                                                                          |
| <p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)</p>                                                                                                                                                                                                                                                                                                                |                                        | <p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)<br/><b>3706 NORTONIA RD 1509</b></p>                                                  |                                                                                                                                                                                                                                                                                                                                                                                  | <p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>                      |                                                                                                          |
| <p><b>21D. TIME OF INJURY (APPROX.)</b><br/><b>10-19-71</b></p>                                                                                                                                                                                                                                                                                                                                                    |                                        | <p><b>21E. INJURY OCCURRED</b><br/>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/></p>                                                      |                                                                                                                                                                                                                                                                                                                                                                                  | <p><b>21F. HOW DID INJURY OCCUR?</b><br/><b>SLIPPED AND FELL.</b></p>                                       |                                                                                                          |
| <p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>10-21-71</b> <b>to</b> <b>11-8-71</b> <b>that (I) (we) last saw the deceased alive on</b> <b>11-8-71</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>                                                        |                                        |                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                             |                                                                                                          |
| <p><b>23A. SIGNATURE</b><br/><b>Parvez I. Shah</b></p>                                                                                                                                                                                                                                                                                                                                                             |                                        |                                                                                                                                                                                          | <p><b>23B. DATE SIGNED</b><br/><b>11-8-71</b></p>                                                                                                                                                                                                                                                                                                                                |                                                                                                             | <p><b>23C. PHYSICIAN'S NAME (Type)</b><br/><b>PARVEZ I. SHAH</b></p>                                     |
| <p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br/><b>Burial</b></p>                                                                                                                                                                                                                                                                                                                                           |                                        | <p><b>24B. DATE</b><br/><b>11/11/71</b></p>                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                  | <p><b>24C. NAME of CEMETERY or CREMATORY</b><br/><b>New Cathedral</b></p>                                   |                                                                                                          |
| <p><b>25A. DATE REC'D BY HEALTH DEPT.</b><br/><b>NOV 11 1971</b></p>                                                                                                                                                                                                                                                                                                                                               |                                        | <p><b>25B. NAME OF REGISTRAR</b><br/><b>John E. Fisher, M.D.</b></p>                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                  | <p><b>25C. FUNERAL DIRECTOR</b> <b>Witzke, 1630 Edmondson Avenue 21228</b></p>                              |                                                                                                          |

Unable to contact No. 4

Phone has been disconnected.



D-120 71 10386

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10386

BIRTH NO.

|                                                                                                                                                                                                              |  |                                                                                                                                                     |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Howard Davis</b>                                                                                                                                                |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>11 4 71 7:25 p.m.</b> |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>43 So. Balto. Gen. Hospital</b><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>11 4 71 7:25 p.m.</b>                                                                          |  |
| 6. SEX<br><b>male</b>                                                                                                                                                                                        |  | 7. RACE<br><b>Negro</b>                                                                                                                             |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                             |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>2301</b>                  |  |
| 9. DATE OF BIRTH<br><b>MAR 12 1919</b>                                                                                                                                                                       |  | 10. AGE (In years last birthday)<br><b>52</b>                                                                                                       |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>BALTO Md</b>                                                                                                                                                 |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                        |  |
| 13. FATHER'S NAME<br><b>JEFF DAVIS</b>                                                                                                                                                                       |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>AL-2301</b>                                        |  |
| 15. MOTHER'S MAIDEN NAME<br><b>ANNIE FASON WILLIAMS</b>                                                                                                                                                      |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                             |  |
| 17. SOCIAL SECURITY NO.<br><b>218-03-5542</b>                                                                                                                                                                |  | 18. INFORMANT ADDRESS<br><b>ANNIE F WILLIAMS 134 W. CROSS</b>                                                                                       |  |

|                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                       |  |                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 19. <b>E965X1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. |  | CAUSE OF DEATH<br><b>Gunshot wound of chest</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                          |  |                                                                                                                                                                       |  |                                              |  |

|                                                                                             |  |                                                                                                                   |  |                                                                                                                       |  |
|---------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------|--|
| 20A. DATE OF OPERATION<br><b>2</b>                                                          |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                  |  | 21. AUTOPSY? (Yes or No)<br><b>yes</b>                                                                                |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>STREET</b>         |  | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>Leadenhall &amp; Hamburg Sts. 2301</b> |  |
| 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)<br><b>11 4 71 7:10 p.m.</b>       |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | 22F. HOW DID INJURY OCCUR?<br><b>Shot by unknown assailant.</b>                                                       |  |

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                |  |                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|-------------------------------|--|
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                |  |                               |  |
| ACTUAL SIGNATURE<br><b>Peter Lipkovic, M.D.</b>                                                                                                                                                                                                                                                                                                                                                               |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                |  | DATE SIGNED<br><b>11/5/71</b> |  |
| EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                        |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                               |  | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>            |  |                               |  |

|                                                                  |  |                                                       |  |                                                        |  |
|------------------------------------------------------------------|--|-------------------------------------------------------|--|--------------------------------------------------------|--|
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>        |  | 24B. DATE<br><b>11-10-71</b>                          |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>MT AUBURN</b> |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTI Md</b> |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 11 1971</b> |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fason, M.D.</b> |  |
| 25C. FUNERAL DIRECTOR<br><b>I. L. BROWN &amp; SON</b>            |  | 25D. ADDRESS<br><b>123 W. MONTGOMERY ST</b>           |  |                                                        |  |

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BOBO MO

JEFF DAVIS

BOBO FROM WILLIAMS

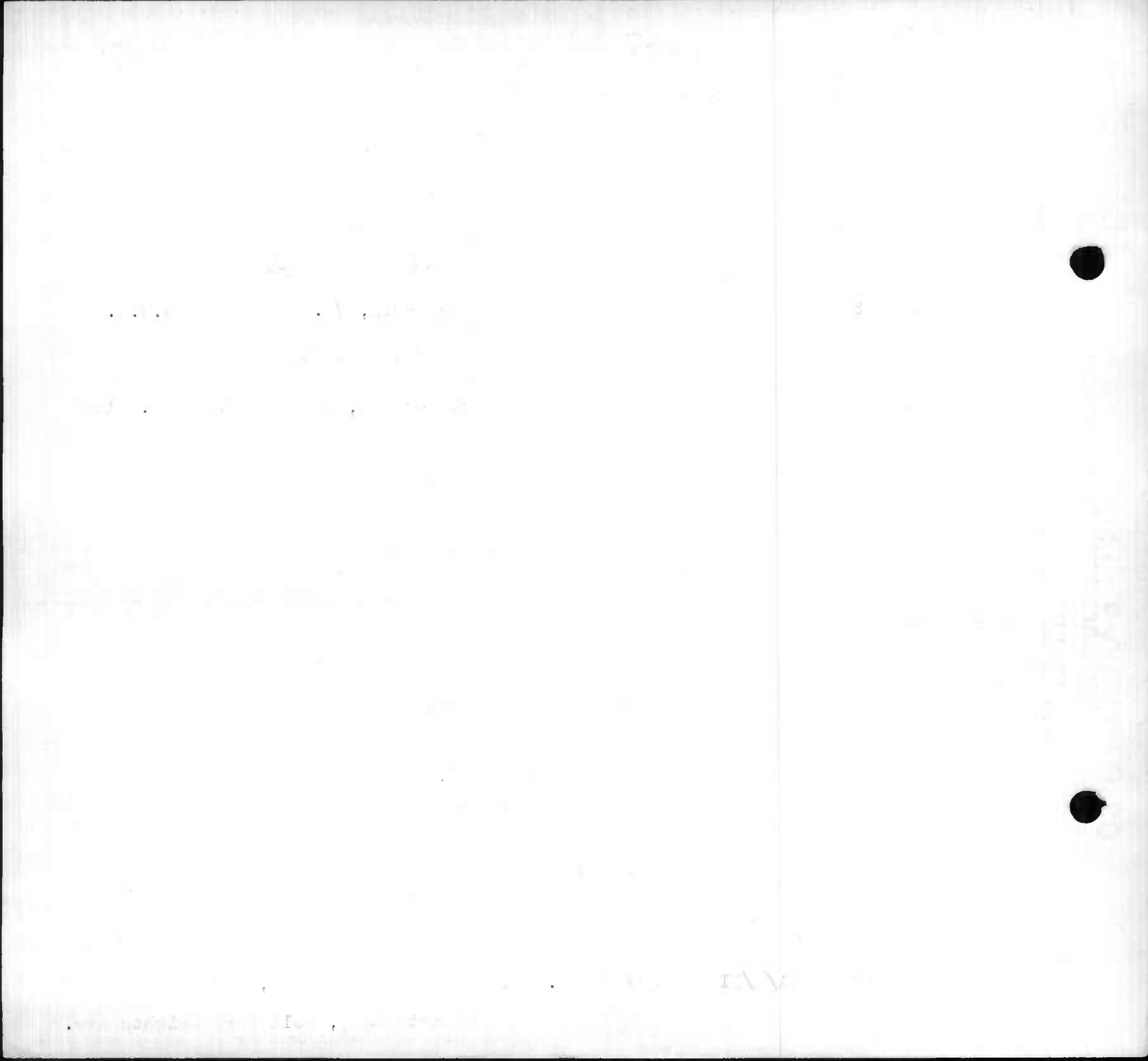
BOBO FROM WILLIAMS 1978

Jeff Davis

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

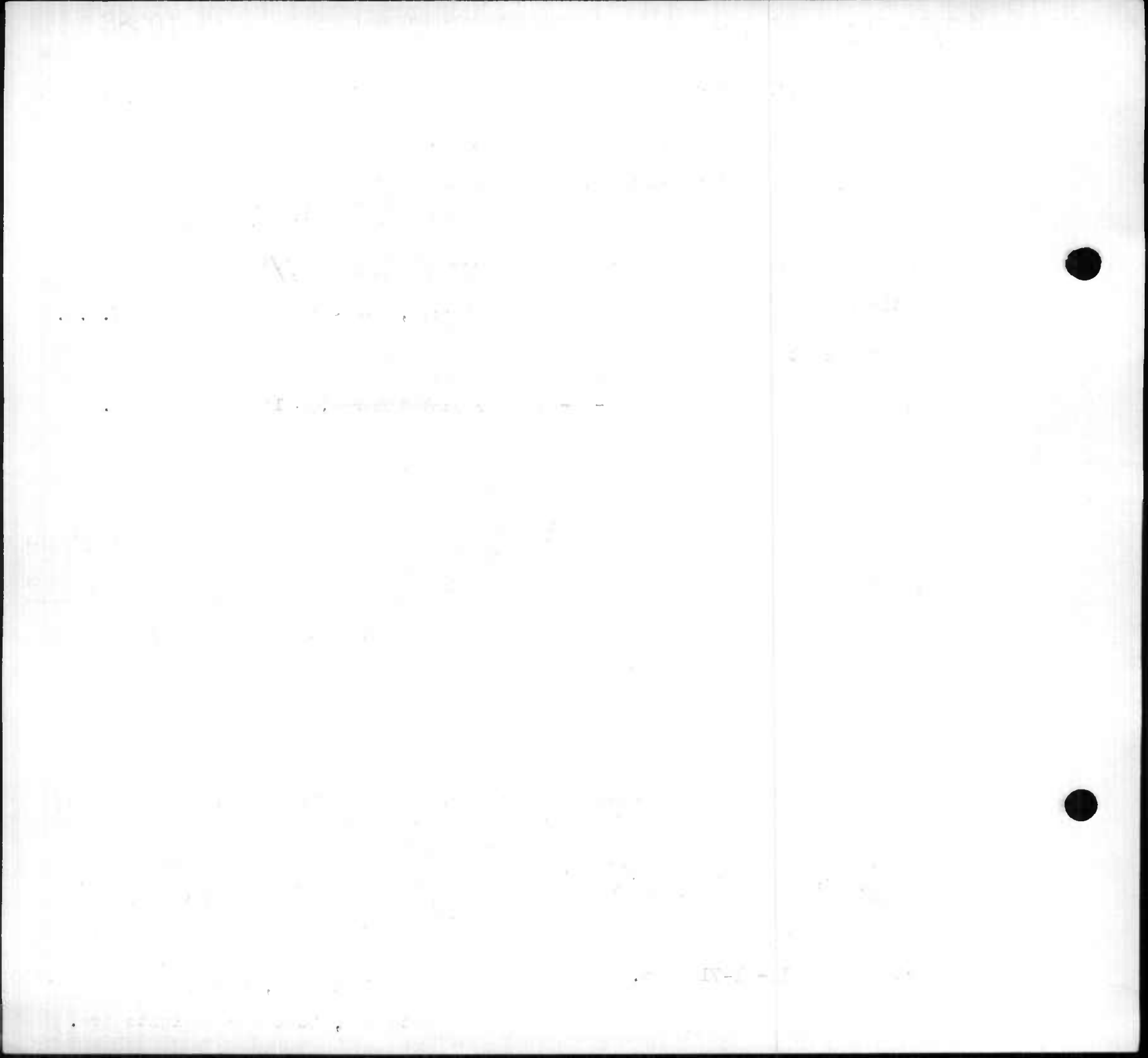
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |  |                                                               |                                                                                                                                                                                                                                                                                                                                          |                                                                            |  |                                                   |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--|---------------------------------------------------|--|
| 71 10387 CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |  |                                                               | REG. NO. 71 10387                                                                                                                                                                                                                                                                                                                        |                                                                            |  |                                                   |  |
| N-630<br>BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 71 10387                                                                                                                                                    |  |                                                               | 71 10387                                                                                                                                                                                                                                                                                                                                 |                                                                            |  |                                                   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>NORWOOD, BERNICE SARAH</b>                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |  |                                                               | 2. DATE AND HOUR OF DEATH<br><b>11-5-71 10-30 A.M.</b>                                                                                                                                                                                                                                                                                   |                                                                            |  |                                                   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Provident Hospital</b>                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |  |                                                               | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>3402 Grantley Road 1511</b> |                                                                            |  |                                                   |  |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                     | 6. RACE<br><b>Black</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>06-28-21</b>                           | 9. AGE (in years last birthday)<br><b>50</b>                                                                                                                                                                                                                                                                                             | 10. UNDER 1 Yr. Months Days                                                |  | 11. UNDER 24 Hrs. Hours Min.                      |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Florist</b>                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |  | 10B. KIND OF BUSINESS OR INDUSTRY                             |                                                                                                                                                                                                                                                                                                                                          | 11. BIRTHPLACE (State or foreign country)<br><b>Merherrin, Va.</b>         |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>     |  |
| 13. FATHER'S NAME<br><b>Spry Jackson</b>                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |  |                                                               | 14. MOTHER'S MAIDEN NAME<br><b>Maggie Knight</b>                                                                                                                                                                                                                                                                                         |                                                                            |  |                                                   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.                                       |                                                                                                                                                                                                                                                                                                                                          | 17. INFORMANT<br><b>Carl Norwood, 3402 Grantley Rd. 21215</b>              |  |                                                   |  |
| 18. <b>159X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Generalized Carcinomatosis.</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Carcinoma G.I. TRACT WITH Metastases.</b> |                         |                                                                                                                                                             |  |                                                               | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C)                                                                                                                                                                                                                      |                                                                            |  |                                                   |  |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |  |                                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                             |                                                                            |  |                                                   |  |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                        |                                                                                                                                                                                                                                                                                                                                          | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?       |  |                                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                       |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR?                                  |                                                                                                                                                                                                                                                                                                                                          | (If in Baltimore City, give exact location)                                |  |                                                   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?                                    |                                                                                                                                                                                                                                                                                                                                          |                                                                            |  |                                                   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11-3-71</b> to <b>11-5-71</b> that (I) (we) last saw the deceased alive on <b>11-5-71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                     |                         |                                                                                                                                                             |  |                                                               |                                                                                                                                                                                                                                                                                                                                          |                                                                            |  |                                                   |  |
| 23A. SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |  |                                                               | 23B. DATE SIGNED<br><b>11/5/71</b>                                                                                                                                                                                                                                                                                                       |                                                                            |  | 23C. PHYSICIAN'S NAME (Type)<br><b>Y. BABURAO</b> |  |
| 23D. ADDRESS<br><b>PROVIDENT HOSPITAL, 2600 Liberty Hts. Ave. BALTO MD</b>                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |  |                                                               | 23E. DEGREE                                                                                                                                                                                                                                                                                                                              |                                                                            |  |                                                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                   |                         | 24B. DATE<br><b>11/9/71</b>                                                                                                                                 |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Carver Mem. Park</b> |                                                                                                                                                                                                                                                                                                                                          | 24D. LOCATION (City, town, or county) (State)<br><b>Muirkirk, Maryland</b> |  | 24E. ADDRESS                                      |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 11 1971</b>                                                                                                                                                                                                                                                                                                                                                                                       |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>                                                                                                     |  | 25C. FUNERAL DIRECTOR<br><b>Kenneth Law</b>                   |                                                                                                                                                                                                                                                                                                                                          | 25D. ADDRESS<br><b>4611 Park Heights Ave.</b>                              |  |                                                   |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

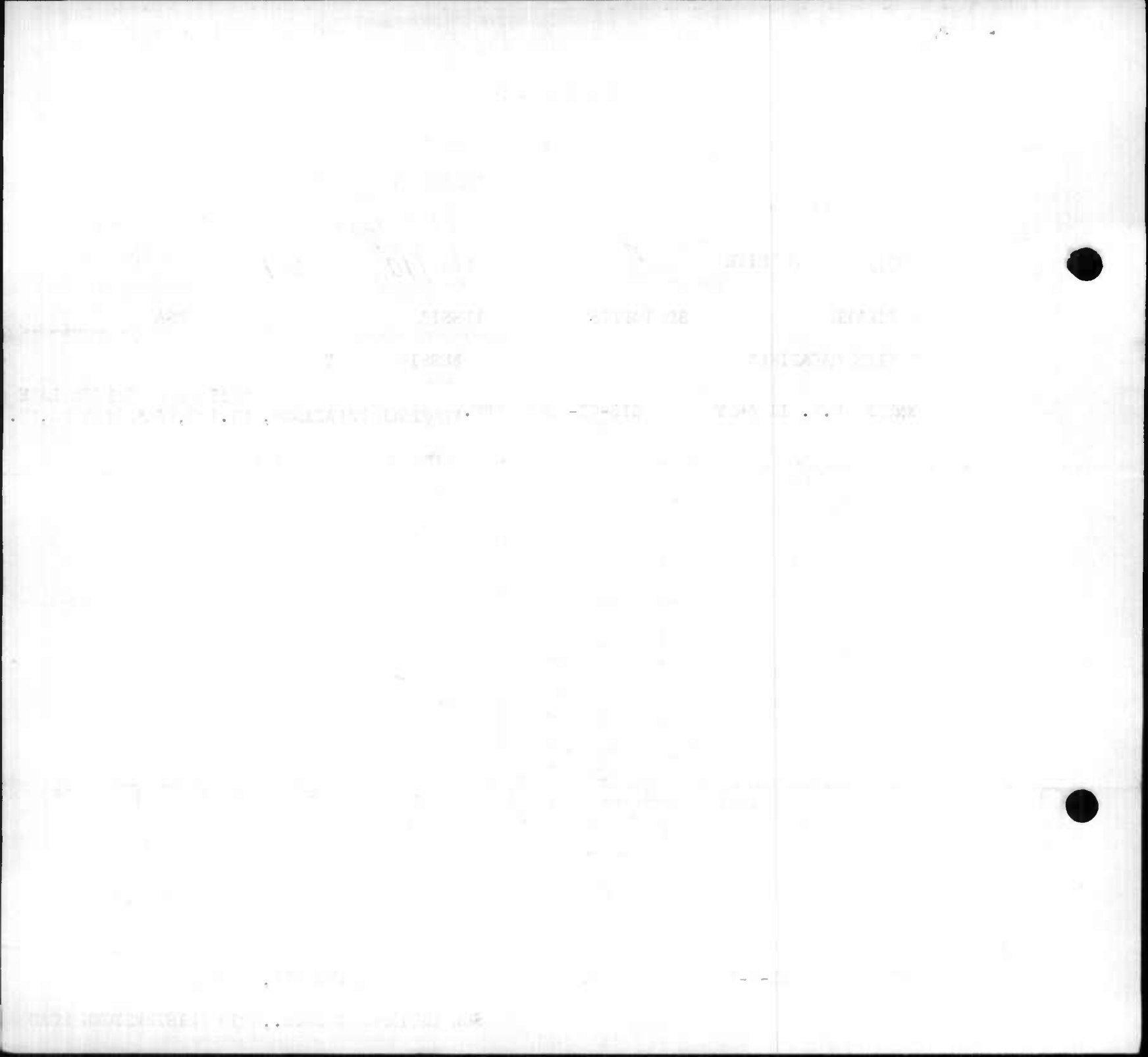
| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                                        |                                                                                                                                    | REG. NO. <u>71 10388</u>                                                    |                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| BIRTH NO. <u>B-620 71 10388</u>                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                                        |                                                                                                                                    |                                                                             |                                                                                    |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Bertha Burke</u>                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                                        | 2. DATE AND HOUR OF DEATH<br><u>Nov 8, 1971 15:45 P.M.</u>                                                                         |                                                                             |                                                                                    |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                                        | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>md.</u> B. COUNTY <u>1608</u> |                                                                             |                                                                                    |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>university of md. Hospital 38</u>                                                                                                                                                                                                          |                         |                                                                                                                                                                        | C. CITY OR TOWN<br><u>Balto</u>                                                                                                    |                                                                             | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                                        | E. STREET AND NUMBER<br><u>3718 Woodridge 21229</u>                                                                                |                                                                             |                                                                                    |
| 5. SEX<br><u>FEMALE</u>                                                                                                                                                                                                                                                                                                                                    | 6. RACE<br><u>BLACK</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>4-5-1900</u>                                                                                                | 9. AGE (in years last birthday)<br><u>71</u>                                | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.                        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>                                                                                                                                                                                                                                              |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                      |                                                                                                                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Tocca, Georgia</u>          |                                                                                    |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                                        |                                                                                                                                    |                                                                             |                                                                                    |
| 13. FATHER'S NAME<br><u>Bud Scott</u>                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                                        | 14. MOTHER'S MAIDEN NAME                                                                                                           |                                                                             |                                                                                    |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                      |                         | 16. SOCIAL SECURITY NO.<br><u>239-07-0334</u>                                                                                                                          |                                                                                                                                    | 17. INFORMANT ADDRESS<br><u>Froyce Willoughby 3718 Woodridge Rd.</u>        |                                                                                    |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                                        |                                                                                                                                    |                                                                             |                                                                                    |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>Hyperosmolar State</u>                                                                                                                            |                         |                                                                                                                                                                        |                                                                                                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hrs</u>               |                                                                                    |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Sepsis</u>                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                                        |                                                                                                                                    | 7-10 days                                                                   |                                                                                    |
| (B) ANTECEDENT CAUSES DUE TO, OR AS A CONSEQUENCE OF:<br><u>Diabetes mellitus</u>                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                                        |                                                                                                                                    | many yrs                                                                    |                                                                                    |
| (C) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>Hemispheric cerebral infarct</u>                                                                                                                                                                                                       |                         |                                                                                                                                                                        |                                                                                                                                    | 1 month                                                                     |                                                                                    |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                       |                         |                                                                                                                                                                        |                                                                                                                                    |                                                                             |                                                                                    |
| 19A. DATE OF OPERATION<br><u>0 0</u>                                                                                                                                                                                                                                                                                                                       |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>0</u>                                                                                                           |                                                                                                                                    | 20A. AUTOPSY? (Yes or No)                                                   |                                                                                    |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                                        |                                                                                                                                    |                                                                             |                                                                                    |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                      |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                               |                                                                                                                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)    |                                                                                    |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                  |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                 |                                                                                                                                    | 21F. HOW DID INJURY OCCUR?                                                  |                                                                                    |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-14</u> 19 <u>71</u> to <u>11-8</u> 19 <u>71</u> and that (I) (we) last saw the deceased alive on <u>11-8</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                                        |                                                                                                                                    |                                                                             |                                                                                    |
| 23A. SIGNATURE<br><u>William Stewart MD</u>                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                                        |                                                                                                                                    | 23B. DATE SIGNED<br><u>11/8/71</u>                                          |                                                                                    |
| 23C. PHYSICIAN'S NAME (Type)<br><u>WILLIAM STEWART MD</u>                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                                        |                                                                                                                                    | 23D. ADDRESS<br><u>1327 MERIDIAN DRIVE 21239</u>                            |                                                                                    |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                  |                         | 24B. DATE<br><u>11-11-71</u>                                                                                                                                           |                                                                                                                                    | 24C. NAME of CEMETERY or CREMATORY<br><u>Mt. Auburn</u>                     |                                                                                    |
| 24D. LOCATION<br><u>Baltimore, Maryland</u>                                                                                                                                                                                                                                                                                                                |                         | 24E. NAME of REGISTRAR<br><u>Robert E. Fisher, R.D.</u>                                                                                                                |                                                                                                                                    |                                                                             |                                                                                    |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 11 1971</u>                                                                                                                                                                                                                                                                                                      |                         | 25B. NAME OF REGISTRAR<br><u>Robert E. Fisher, R.D.</u>                                                                                                                |                                                                                                                                    | 25C. FUNERAL DIRECTOR ADDRESS<br><u>Kenneth Law, 4611 Park Heights Ave.</u> |                                                                                    |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                   |                         | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                         |                                   | REG. NO. <u>71 10389</u>                                                                                               |                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <u>HARRY A. MAGAZINER</u>                                                                                                                                                                                                                                                                                                                                            |                         | 2. DATE AND HOUR OF DEATH<br><u>NOV-8, 1971</u>   <u>2:25 A.M.</u>                                                                               |                                   |                                                                                                                        |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                      |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u>         |                                   |                                                                                                                        |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>42 Sinai Hosp.</u>                                                                                                                                                                                                                                                                                                                                               |                         | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                             |                                   | C. CITY OR TOWN <u>RANDALLSTOWN</u> D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                           |
| E. STREET AND NUMBER<br><u>8517 Glenn Michael Lane.</u>                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                  |                                   |                                                                                                                        |                                                           |
| 5. SEX<br><u>MALE</u>                                                                                                                                                                                                                                                                                                                                                                                       | 6. RACE<br><u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7/5/10</u> | 9. AGE (in years last birthday)<br><u>61</u>                                                                           | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>EMPLOYEE</u>                                                                                                                                                                                                                                                                                              |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>SUN PAPERS</u>                                                                                           |                                   | 11. BIRTHPLACE (State or foreign country)<br><u>RUSSIA</u>                                                             |                                                           |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                  |                                   |                                                                                                                        |                                                           |
| 13. FATHER'S NAME<br><u>RUEBEN MAGAZINER</u>                                                                                                                                                                                                                                                                                                                                                                |                         | 14. MOTHER'S MAIDEN NAME<br><u>BESSIE ?</u>                                                                                                      |                                   |                                                                                                                        |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO YES</u> <u>W.W. II ARMY</u>                                                                                                                                                                                                                                                               |                         | 16. SOCIAL SECURITY NO.<br><u>213-03-2360</u>                                                                                                    |                                   | 17. INFORMANT<br><u>MRS. FLORENCE MAGAZINER, APT. 102, RANDALLSTOWN, MD.</u>                                           |                                                           |
| 18. <u>430.0 I</u> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>SUBARACHNOID HEMORRHAGE</u><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>HYPER TENSION</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>12 hrs</u>                                                                                    |                                   |                                                                                                                        |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                  |                                   |                                                                                                                        |                                                           |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                                                                          |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |                                   | 20A. AUTOPSY? (Yes or No)<br><u>NO</u>                                                                                 |                                                           |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                  |                                   |                                                                                                                        |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                              |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                         |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                               |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                   |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                           |                                   | 21F. HOW DID INJURY OCCUR?                                                                                             |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <u>NOV 7</u> 19 <u>71</u> to <u>NOV 8</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>NOV 8</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                    |                         |                                                                                                                                                  |                                   |                                                                                                                        |                                                           |
| 23A. SIGNATURE<br><u>Robert L. Brenner, M.D.</u>                                                                                                                                                                                                                                                                                                                                                            |                         | 23B. DATE SIGNED<br><u>11/8/71</u>                                                                                                               |                                   |                                                                                                                        |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Robert L. Brenner, M.D.</u>                                                                                                                                                                                                                                                                                                                                              |                         | 23D. ADDRESS<br><u>Sinai Hosp.</u>                                                                                                               |                                   |                                                                                                                        |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                                                                                   |                         | 24B. DATE<br><u>11-9-71</u>                                                                                                                      |                                   | 24C. NAME OF CEMETERY or CREMATORY<br><u>BETH TFILOH</u>                                                               |                                                           |
| 24D. LOCATION (City, town, or county) (State)<br><u>BALTIMORE, MARYLAND</u>                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                  |                                   |                                                                                                                        |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 11 1971</u>                                                                                                                                                                                                                                                                                                                                                       |                         | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, M.D.</u>                                                                                          |                                   | 25C. FUNERAL DIRECTOR<br><u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>                                       |                                                           |
| ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                  |                                   |                                                                                                                        |                                                           |

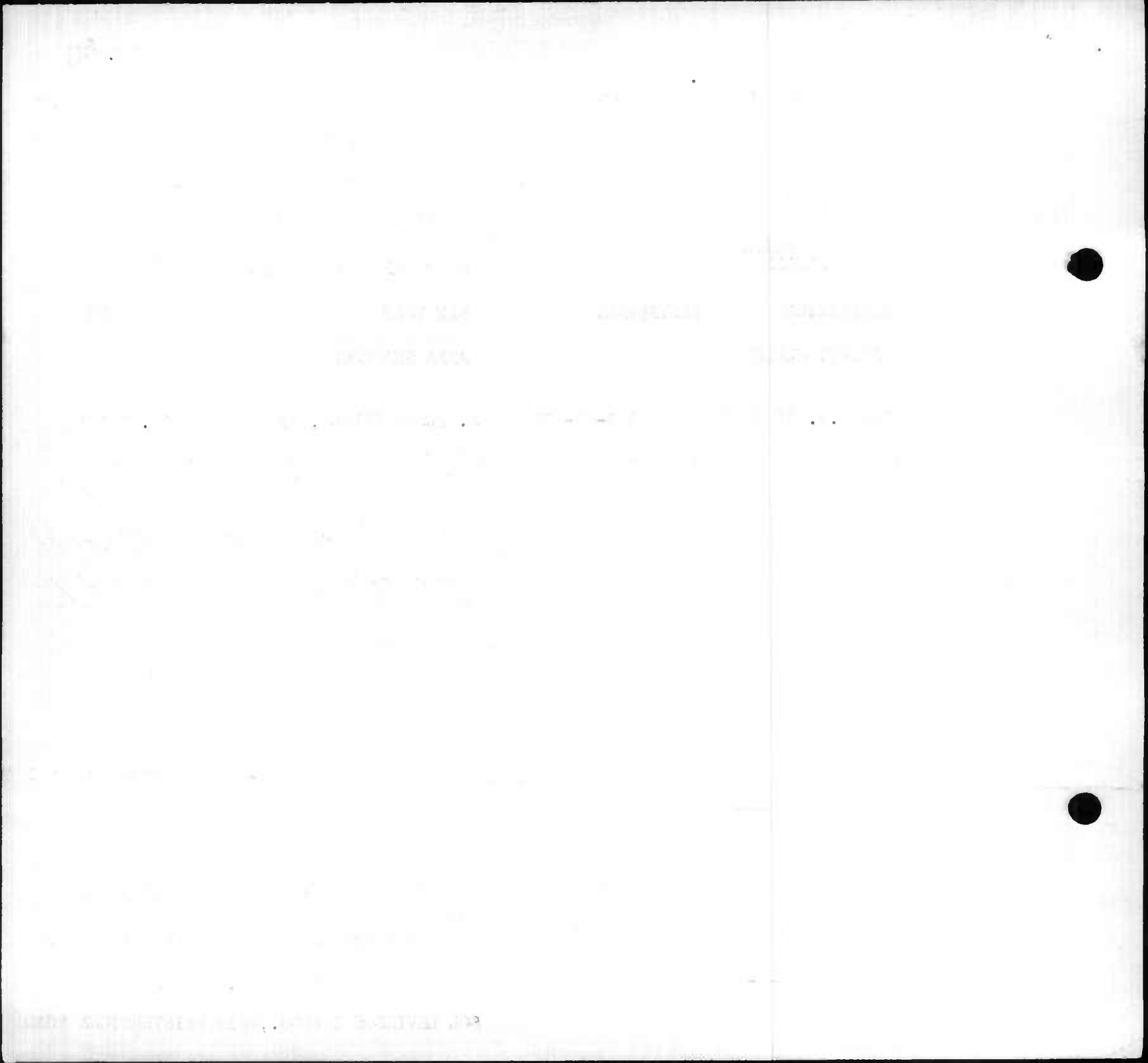




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

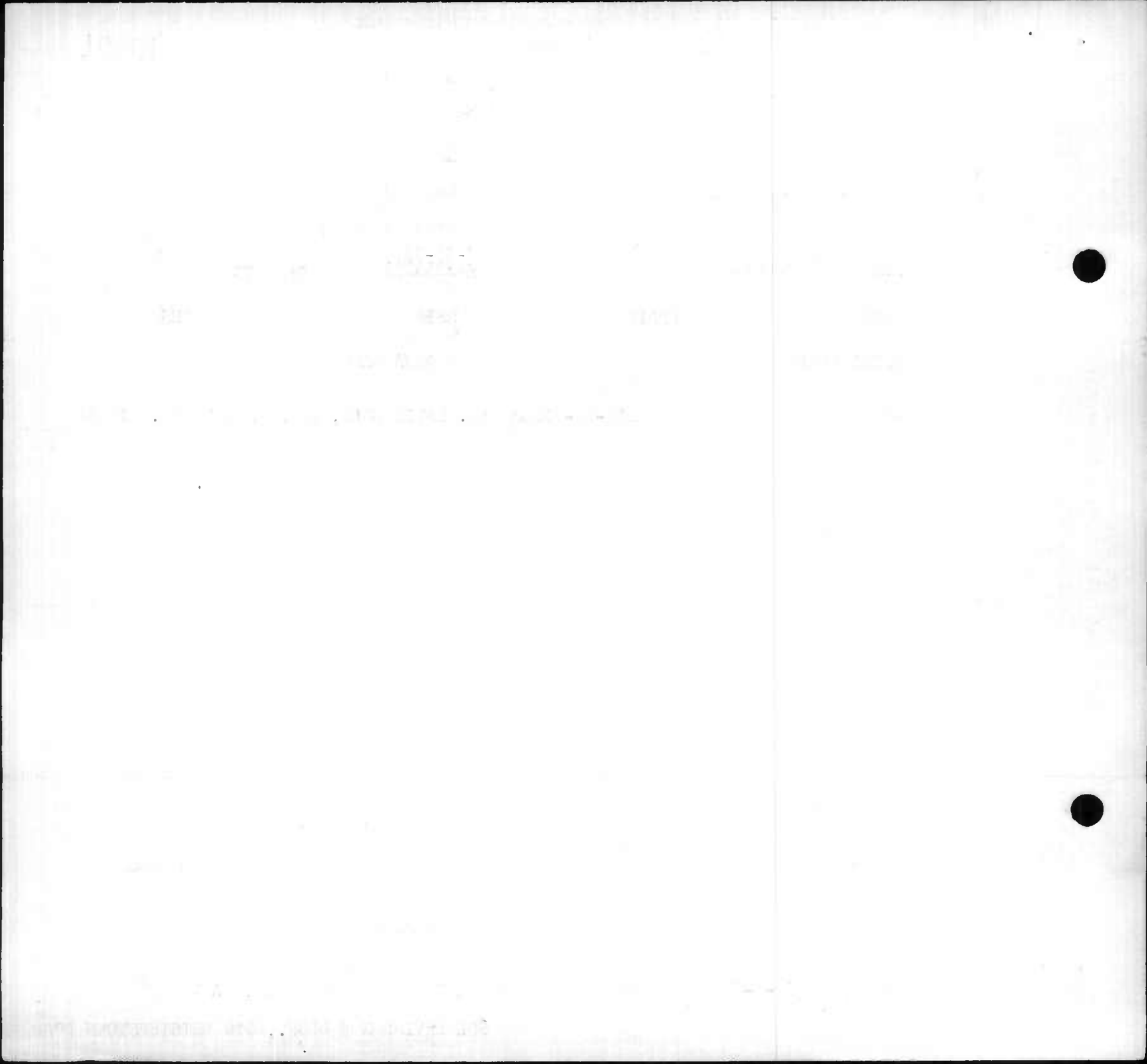
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                  |                      |                                                                                                                                                                                                                                                                                                                                                     |                                                                                       | REG. NO. <u>71 10390</u>                                                                          |                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| G-460 <u>71 10390</u>                                                                                                                             |                      |                                                                                                                                                                                                                                                                                                                                                     |                                                                                       | CERTIFICATE OF DEATH                                                                              |                                                                                            |
| BIRTH NO. <u>71 10390</u>                                                                                                                         |                      | 1. NAME OF DECEASED (Type or Print) <u>DANIEL GELLER. M.</u>                                                                                                                                                                                                                                                                                        |                                                                                       | 2. DATE AND HOUR OF DEATH <u>11-7-71 4:30 A.M.</u>                                                |                                                                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                            |                      |                                                                                                                                                                                                                                                                                                                                                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |                                                                                                   |                                                                                            |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL OF BALTIMORE INC.</u> |                      |                                                                                                                                                                                                                                                                                                                                                     | A. STATE <u>MARYLAND.</u> B. COUNTY <u>2775</u>                                       |                                                                                                   |                                                                                            |
|                                                                                                                                                   |                      |                                                                                                                                                                                                                                                                                                                                                     | C. CITY OR TOWN <u>BALTIMORE</u>                                                      |                                                                                                   | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|                                                                                                                                                   |                      |                                                                                                                                                                                                                                                                                                                                                     | E. STREET AND NUMBER <u>117 HAMILL RD #10</u>                                         |                                                                                                   |                                                                                            |
| 5. SEX <u>MALE</u>                                                                                                                                | 6. RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                            | 8. DATE OF BIRTH <u>6-7-10</u>                                                        | 9. AGE (in years last birthday) <u>61</u>                                                         | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROPRIETOR</u>                                     |                      | 10B. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>                                                                                                                                                                                                                                                                                                 |                                                                                       | 11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>                                         |                                                                                            |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                                                                                           |                      | 13. FATHER'S NAME <u>BARNETT GELLER</u>                                                                                                                                                                                                                                                                                                             |                                                                                       | 14. MOTHER'S MAIDEN NAME <u>ANNA SHAMROCK</u>                                                     |                                                                                            |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES W.W. II ARMY</u>                  |                      | 16. SOCIAL SECURITY NO. <u>101-07-5716</u>                                                                                                                                                                                                                                                                                                          |                                                                                       | 17. INFORMANT ADDRESS <u>MRS. PEARL GELLER, 11 F HAMILL RD. #21210</u>                            |                                                                                            |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>CARDIOGENIC SHOCK.</u>                                                                      |                      | CAUSE OF DEATH <u>RENAL FAILURE</u>                                                                                                                                                                                                                                                                                                                 |                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>                                        |                                                                                            |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)       |                      | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>MYOCARDIAL INFARCTION</u>                                                                                                                                                                                                                                                                    |                                                                                       | <u>3 WEEKS</u>                                                                                    |                                                                                            |
| ANTECEDENT CAUSES                                                                                                                                 |                      | (B) DUE TO, OR AS A CONSEQUENCE OF: <u>ATHEROSCLEROSIS</u>                                                                                                                                                                                                                                                                                          |                                                                                       | <u>10-15 YRS.</u>                                                                                 |                                                                                            |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                         |                      | (C)                                                                                                                                                                                                                                                                                                                                                 |                                                                                       |                                                                                                   |                                                                                            |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                  |                      |                                                                                                                                                                                                                                                                                                                                                     |                                                                                       |                                                                                                   |                                                                                            |
| 19A. DATE OF OPERATION <u>0</u>                                                                                                                   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                    |                                                                                       | 20A. AUTOPSY? (Yes or No)                                                                         |                                                                                            |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                              |                      | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                               |                                                                                       | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)          |                                                                                            |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                          |                      | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)                                                                                                                                                                                                                                                                                            |                                                                                       | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                                                                            |
| 21F. HOW DID INJURY OCCUR?                                                                                                                        |                      | 22. I certify that (I) (this hospital) attended the deceased from <u>10-22</u> <u>1971</u> to <u>11-7</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>11-7</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                                                                       |                                                                                                   |                                                                                            |
| 23A. SIGNATURE <u>GUTIERREZ M.D.</u>                                                                                                              |                      | 23B. DATE SIGNED <u>11-7-71</u>                                                                                                                                                                                                                                                                                                                     |                                                                                       | 23C. PHYSICIAN'S NAME (Type) <u>FELIX GUTIERREZ M.D.</u>                                          |                                                                                            |
| 23D. ADDRESS <u>SINAI HOSPITAL OF BALTO INC.</u>                                                                                                  |                      | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>                                                                                                                                                                                                                                                                                              |                                                                                       |                                                                                                   |                                                                                            |
| 24B. DATE <u>11-9-71</u>                                                                                                                          |                      | 24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE HEBREW</u>                                                                                                                                                                                                                                                                                          |                                                                                       | 24D. LOCATION (City, town, or county) (State) <u>RANDALLSTOWN, MARYLAND</u>                       |                                                                                            |
| 25A. DATE RECD BY HEALTH DEPT. <u>NOV 11 1971</u>                                                                                                 |                      | 25B. NAME OF REGISTRAR <u>Valerie L. Kelly, R.D.</u>                                                                                                                                                                                                                                                                                                |                                                                                       | 25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>             |                                                                                            |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                             |                               |                                                                                               |                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------|
| G 430 71 10391                                                                                                                                                                                                                                                                                                       |                  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |                               | REG. NO. 71 10391                                                                             |                                                |
| BIRTH NO.                                                                                                                                                                                                                                                                                                            |                  | 1. NAME OF DECEASED<br>(Type or Print) ISADORE GOLD                                                                                                         |                               | 2. DATE AND HOUR OF DEATH<br>11-6-71 8:12 P.M.                                                |                                                |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>PLEASANT MANOR NURSING HOME                                                                                                                                                                                                                            |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Md.<br>B. COUNTY                                          |                               | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                         |                  | C. CITY OR TOWN<br>BALTO                                                                                                                                    |                               | E. STREET AND NUMBER<br>3009 Oakley Ave.                                                      |                                                |
| 5. SEX<br>MALE                                                                                                                                                                                                                                                                                                       | 6. RACE<br>WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>4-15-1898 | 9. AGE (In years last birthday)<br>73                                                         | If Under 1 Yr. Months<br>If Under 24 Hrs. Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>SHOE                                                                                                                                                                                                                  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>REPAIR                                                                                                                 |                               | 11. BIRTHPLACE (State or foreign country)<br>RUSSIA                                           |                                                |
| 13. FATHER'S NAME<br>LAZAR GOLD                                                                                                                                                                                                                                                                                      |                  | 14. MOTHER'S MAIDEN NAME<br>ANNA BASHA ?                                                                                                                    |                               | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                           |                                                |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO                                                                                                                                                                                                       |                  | 16. SOCIAL SECURITY NO.<br>218-32-5398A                                                                                                                     |                               | 17. INFORMANT<br>MRS. KATIE GOLD, 3009 OAKLEY AVE. #21215                                     |                                                |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>582 x 1                                                                                                         |                  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Metabolic acidosis                                                                                |                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5d's.                                         |                                                |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                       |                  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br>Chronic renal disease                                                                                                |                               | 3 yrs.                                                                                        |                                                |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>II<br>② perinephric abscess                                                                                                                                                      |                  |                                                                                                                                                             |                               | 1 month                                                                                       |                                                |
| 19A. DATE OF OPERATION<br>P                                                                                                                                                                                                                                                                                          |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                               | 20A. AUTOPSY? (Yes or No)                                                                     |                                                |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                     |                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                            |                  | 21E. INJURY OCCURRED<br>White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>                                                   |                               | 21F. HOW DID INJURY OCCUR?                                                                    |                                                |
| 22. I certify that (he) (this hospital) attended the deceased from Oct. 26 19 71 to Nov. 6 19 71 that (he) (we) last saw the deceased alive on Nov. 6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |                                                                                                                                                             |                               |                                                                                               |                                                |
| 23A. SIGNATURE<br>Michael G. Hayes, M.D.                                                                                                                                                                                                                                                                             |                  | 23B. DATE SIGNED                                                                                                                                            |                               | 23C. PHYSICIAN'S NAME (Type)<br>Michael G. Hayes                                              |                                                |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                                   |                  | 24B. DATE<br>11-8-71                                                                                                                                        |                               | 24C. NAME OF CEMETERY OR CREMATORY<br>BOBROISKER BENEFICIAL CIRCLE                            |                                                |
| 25A. DATE REC'D BY HEALTH-DEPT.<br>NOV 11 1971                                                                                                                                                                                                                                                                       |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, R.D.                                                                                                            |                               | 25C. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD                         |                                                |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |              |                                                                                                                                                             |                                                                                                                         | REG. NO. 71 10392                     |                                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------------------------|
| T-460                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                             |                                                                                                                         | 71 10392                              |                                                                          |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                             |                                                                                                                         | 71 10392                              |                                                                          |
| 1. NAME OF DECEASED<br>(Type or Print) TAYLOR MARY E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br>11-9-71 1 6 A.M.                                                                           |                                       |                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE B. COUNTY             |                                       |                                                                          |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>444 UNION MEMORIAL HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |              |                                                                                                                                                             | CITY OF Baltimore 2702                                                                                                  |                                       |                                                                          |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |                                                                                                                                                             | C. CITY OR TOWN D. INSIDE CITY LIMITS?<br>Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                       |                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                             | E. STREET AND NUMBER<br>2705 GRINDON AVENUE                                                                             |                                       |                                                                          |
| 5. SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6. RACE<br>W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>03-30-85                                                                                            | 9. AGE (in years last birthday)<br>85 | 10. UNDER 1 Yr. Months Days<br>11 Under 24 Hrs. Hours Min.               |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>COMPANION                                                                                                                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br>HOUSEWORKER                                                                        |                                       | 11. BIRTHPLACE (State or foreign country)<br>MD.                         |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                             |                                                                                                                         |                                       |                                                                          |
| 13. FATHER'S NAME<br>JOHN W. TAYLOR KRICKBAUM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br>LENA LEWIS                                                                                  |                                       |                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO                                                                                                                                                                                                                                                                                                                                                                                                                              |              |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br>520-22-1264                                                                                  |                                       | 17. INFORMANT<br>LENA E. GROSSNICKLE, 2705 GRINDON AVE                   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>174X I<br>CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMATOSIS<br>(B) CA OF BREAST<br>(C) DUE TO, OR AS A CONSEQUENCE OF: congestive heart failure<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>ASCVD |              |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                            |                                       |                                                                          |
| 19A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              |                                                                                                                                                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                        |                                       | 20A. AUTOPSY? (Yes or No)                                                |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                |                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                  |                                       | 21F. HOW DID INJURY OCCUR?                                               |
| 22. I certify that (I) (this hospital) attended the deceased from 11-1-71 19 to 11-9-71 19 that (I) (we) last saw the deceased alive on 11-9-71 19 and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                 |              |                                                                                                                                                             |                                                                                                                         |                                       |                                                                          |
| 23A. SIGNATURE<br>[Signature]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                             | 23B. DATE SIGNED<br>11-9-71                                                                                             |                                       |                                                                          |
| 23C. PHYSICIAN'S NAME (Type)<br>SAIRO RAMIREZ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                             | 23D. ADDRESS<br>MD UNION MEMORIAL HOSPITAL                                                                              |                                       |                                                                          |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                             | 24B. DATE<br>12 Nov. 71                                                                                                 |                                       | 24C. NAME OF CEMETERY OR CREMATORY<br>LORRAINE CEMETERY                  |
| 24D. LOCATION (City, town, or county) (State)<br>BALTO. CO., MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |              |                                                                                                                                                             |                                                                                                                         |                                       |                                                                          |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 11 1971                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |              |                                                                                                                                                             | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, Jr.                                                                         |                                       | 25C. FUNERAL DIRECTOR<br>ULLRICH FUNERAL HOME BALTO. MD. 21206           |

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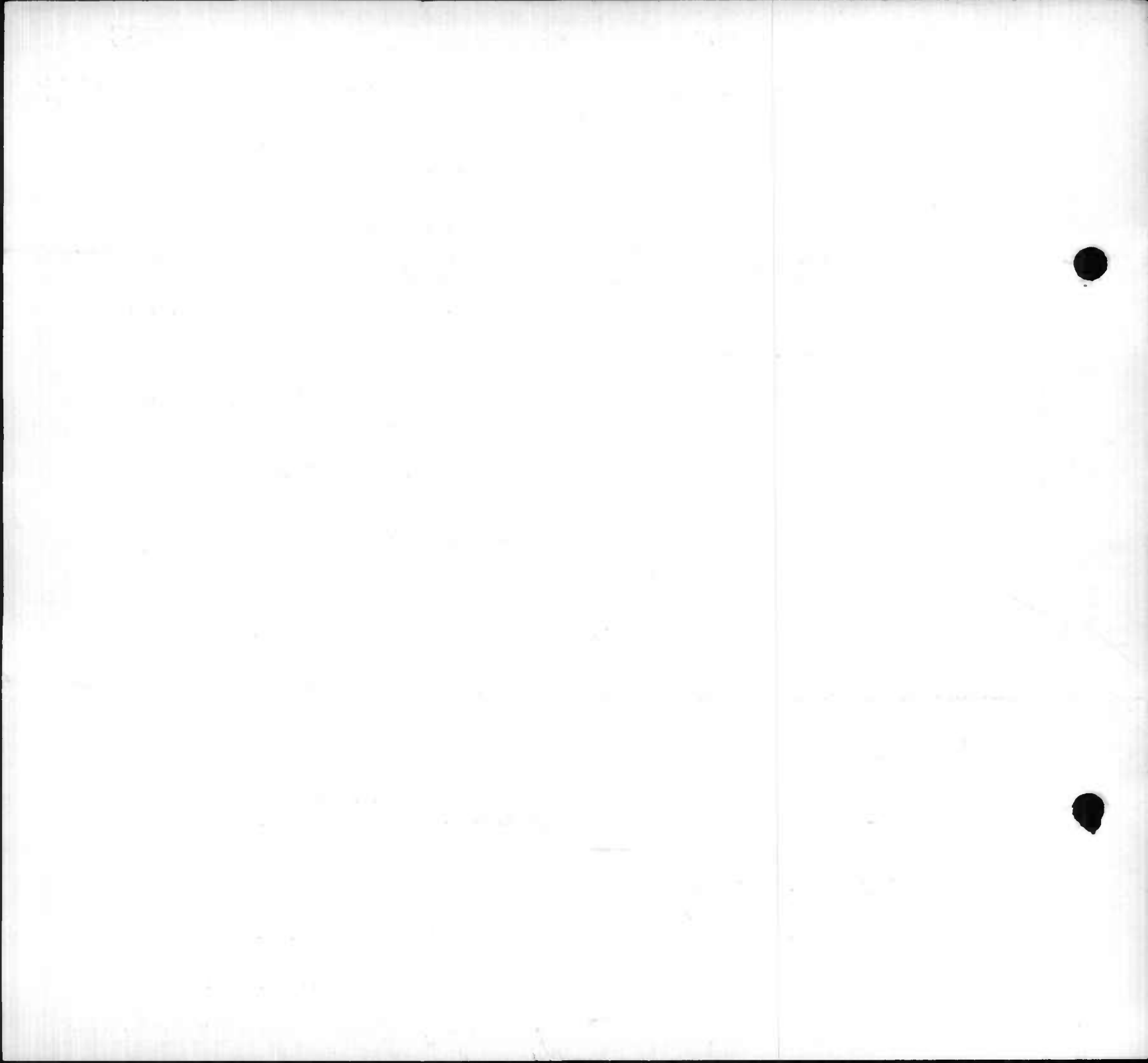
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                          |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                  | REG. NO. <b>71 10393</b>                     |                                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------------------------------------|
| BIRTH NO. <b>11-600 71 10393</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                          | 1. NAME OF DECEASED<br>(Type or Print) <b>MARIE C. MOYER</b>                                                                                                |                                                                                                                                                                                                                                                                                                                  | 2. DATE AND HOUR OF DEATH<br><b>7 Nov 71</b> |                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>90 Gould Convalesc-arium</b>                                                                                                                                                                                                                                                                                                                                                                                                    |                          |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b><br>C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>2908 Yorkway</b> |                                              |                                                                          |
| 5. SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 6. RACE <b>Caucasian</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>24 Oct 1887</b>                                                                                                                                                                                                                                                                              | 9. AGE (In years last birthday) <b>84</b>    | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                          | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                                                                                                                                                                                                                                                          |                                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                            |
| 13. FATHER'S NAME<br><b>Harry B. Littman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                          |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>unobtainable</b>                                                                                                                                                                                                                                                                  |                                              |                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                          | 16. SOCIAL SECURITY NO.                                                                                                                                     | 17. INFORMANT<br><b>Samuel J. Moyer, 2900 Yorkway 21222</b>                                                                                                                                                                                                                                                      |                                              |                                                                          |
| 18. <b>417.301 250.9</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Anteroselectic Heart Disease</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Diabetes; Chronic Brain Syndrome; Hypertension</b> |                          |                                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Anteroselectic Heart Disease</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Chronic Anteroselectic</b><br>(C) _____                                                                                                                |                                              |                                                                          |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                          |                                                                                                                                                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                 |                                              | 20A. AUTOPSY? (Yes or No)                                                |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                          |                                                                                                                                                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                         |                                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                                                                                                                                                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                        |                                              | 21F. HOW DID INJURY OCCUR?                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/6/1971</b> to <b>11/7/1971</b> that (I) (we) last saw the deceased alive on <b>10/27/1971</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                |                          |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                  |                                              |                                                                          |
| 23A. SIGNATURE<br><b>Albert B. Bradley</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                          |                                                                                                                                                             | 23B. DATE SIGNED                                                                                                                                                                                                                                                                                                 |                                              | 23C. PHYSICIAN'S NAME (Type)<br><b>A. B. Bradley, MD</b>                 |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                                                                                                                                                             | 24B. DATE<br><b>10 Nov 71</b>                                                                                                                                                                                                                                                                                    |                                              | 24C. NAME OF CEMETERY or CREMATORY<br><b>Oak Lawn Cemetery</b>           |
| 24D. LOCATION<br><b>Balto.. Co., Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                          |                                                                                                                                                             | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 11 1971</b>                                                                                                                                                                                                                                                            |                                              |                                                                          |
| 25B. NAME OF REGISTRAR<br><b>E. Taylor, R.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                          |                                                                                                                                                             | 25C. FUNERAL DIRECTOR<br><b>Ullrich Funeral Home, Dundalk, Md. 21222</b>                                                                                                                                                                                                                                         |                                              |                                                                          |





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                               |  |                                                                                                           |                                                                                                                                                                                                        | REG. NO. <b>71 10394</b>                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--|
| BIRTH NO. <b>H-520 71 10394</b>                                                                                                                                                                                                                                                                                                        |  | 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN HENNESSY HENNESSY</b>                                      |                                                                                                                                                                                                        | 2. DATE AND HOUR OF DEATH<br><b>7 November 1971 4:45 A.M.</b>            |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>House-in-the-Pines, Belair Rd.</b>                                                                                                                       |  |                                                                                                           | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY <b>2631</b>                                                                  |                                                                          |  |
| 5. SEX <b>MALE</b> 6. RACE <b>CAUCASIAN</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                     |  |                                                                                                           | C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                    |                                                                          |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>WELDER</b>                                                                                                                                                                                                                           |  |                                                                                                           | E. STREET AND NUMBER <b>5837 BELAIR RD</b>                                                                                                                                                             |                                                                          |  |
| 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                      |  |                                                                                                           | 9. AGE (In years last birthday) <b>60</b>                                                                                                                                                              |                                                                          |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>ALBANY, N.Y.</b>                                                                                                                                                                                                                                                                       |  |                                                                                                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                          |                                                                          |  |
| 13. FATHER'S NAME<br><b>WILLIAM HENNESSY</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                           | 14. MOTHER'S MAIDEN NAME<br><b>CATHERINE DESMOND</b>                                                                                                                                                   |                                                                          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                  |  |                                                                                                           | 16. SOCIAL SECURITY NO.<br><b>451-22-3770</b>                                                                                                                                                          |                                                                          |  |
| 17. INFORMANT<br><b>HOUSE-IN-PINES N.H. SPET</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                           | ADDRESS <b>21206</b>                                                                                                                                                                                   |                                                                          |  |
| 18. <b>4974 1019.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b>                                                                                      |  |                                                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                           |                                                                          |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                         |  |                                                                                                           | (A) IMMEDIATE CAUSE <b>Acute Cor Pulmonale</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>Acute Viral Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>Obstructive Pulmonary Emphysema</b> |                                                                          |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Old Tuberculosis; Rheumatoid Arthritis; Asthma</b>                                                                                                                                              |  |                                                                                                           |                                                                                                                                                                                                        |                                                                          |  |
| 19A. DATE OF OPERATION <b>0</b>                                                                                                                                                                                                                                                                                                        |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |                                                                                                                                                                                                        | 20A. AUTOPSY? (Yes or No)                                                |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                                                                                                                                                                                                        | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                              |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                                                                                                                                                                                        | 21F. HOW DID INJURY OCCUR?                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased, from <b>3/12/71</b> to <b>11/21/71</b><br>that (I) (we) last saw the deceased alive on <b>11/6</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                           |                                                                                                                                                                                                        |                                                                          |  |
| 23A. SIGNATURE<br><b>A.B. Bradley</b>                                                                                                                                                                                                                                                                                                  |  |                                                                                                           | 23B. DATE SIGNED<br><b>11/8/71</b>                                                                                                                                                                     |                                                                          |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>A.B. Bradley, MD</b>                                                                                                                                                                                                                                                                                |  |                                                                                                           | 23D. ADDRESS<br><b>4900 Belair Rd. 21206</b>                                                                                                                                                           |                                                                          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>CREMATION</b>                                                                                                                                                                                                                                                                           |  | 24B. DATE<br><b>10 Nov. 71</b>                                                                            |                                                                                                                                                                                                        | 24C. NAME OF CEMETERY or CREMATORY<br><b>LOXDON PARK CREMATORY</b>       |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE, MD.</b>                                                                                                                                                                                                                                                                 |  |                                                                                                           |                                                                                                                                                                                                        |                                                                          |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 11 1971</b>                                                                                                                                                                                                                                                                                  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>                                                   |                                                                                                                                                                                                        | 25C. FUNERAL DIRECTOR<br><b>CLERIGH FUNERAL HOME, DUNDALK, MD.</b>       |  |

Adm. 3/12/71

A.H. has NO former address

In a number of Institutions

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |  | REG. NO. 71 10395                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|
| R-200 10395                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |  | CERTIFICATE OF DEATH                                                                          |  |
| BIRTH NO. <u>Delaware</u>                                                                                                                                                                                                                                                                                                                              |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Tamara Dale Rash</u>                                                                         |  | 2. DATE AND HOUR OF DEATH<br><u>10/7/71</u> <u>3:55 PM.</u>                                   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><u>33 THE JOHNS HOPKINS HOSPITAL</u>                                                                                                                                                                                                                                                         |  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <u>DELAWARE</u> B. COUNTY <u>KENT</u> |  | V 07                                                                                          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>33 THE JOHNS HOPKINS HOSPITAL</u>                                                                                                                                                                                                                                                                           |  | C. CITY OR TOWN<br><u>HARRINGTON</u>                                                                                                   |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| E. STREET AND NUMBER<br><u>RD 3 Box 194</u>                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br><u>FEMALE</u>                                                                                                                |  | 6. RACE<br><u>WHITE</u>                                                                       |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                            |  | 8. DATE OF BIRTH<br><u>8-8-71</u>                                                                                                      |  | 9. AGE (In years last birthday)<br><u>2</u> <u>27</u>                                         |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                            |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                      |  | 11. BIRTHPLACE (State or foreign country)<br><u>Delaware</u>                                  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                                                                                                                                                                                                                                             |  | 13. FATHER'S NAME<br><u>LYMAN RASH</u>                                                                                                 |  | 14. MOTHER'S MAIDEN NAME<br><u>LEILANI GALLOWAY</u>                                           |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><input checked="" type="checkbox"/>                                                                                                                                                                                                        |  | 16. SOCIAL SECURITY NO.                                                                                                                |  | 17. INFORMANT<br><u>Lyman W. Rash, Harrington, Del.</u>                                       |  |
| 18. <u>746.11</u>                                                                                                                                                                                                                                                                                                                                      |  | CAUSE OF DEATH                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>Tauering - Being Anomalous</u>                                                                                                                    |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                 |  | <u>3 months</u>                                                                               |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                         |  | (B) <u>(Ombric - cardiac anomaly)</u>                                                                                                  |  |                                                                                               |  |
| (C)                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                        |  |                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                 |  |                                                                                                                                        |  |                                                                                               |  |
| 19A. DATE OF OPERATION<br><u>3/1/72</u>                                                                                                                                                                                                                                                                                                                |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Tauering - Being Anomalous</u>                                                  |  | 20A. AUTOPSY (Yes or No)<br><u>YES</u>                                                        |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        |  |                                                                                               |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                      |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                               |  | 21C. WHERE DID INJURY OCCUR<br>(If in Baltimore City, give exact location)                    |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                                                                                                                                                                                                                                                           |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                              |  | 21F. HOW DID INJURY OCCUR                                                                     |  |
| 22. I certify that (I) (this hospital) attended the deceased, from <u>10/7</u> 19 <u>71</u> to <u>11/4</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11/4</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  | 23A. SIGNATURE<br><u>JOHN M. MAZUR M.D.</u>                                                                                            |  | 23B. DATE SIGNED                                                                              |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>John M. Mazur M.D.</u>                                                                                                                                                                                                                                                                                              |  | 23D. ADDRESS<br><u>THE JOHNS HOPKINS HOSPITAL</u>                                                                                      |  |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                              |  | 24B. DATE<br><u>11/7/71</u>                                                                                                            |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Odd Fellows Cemetery</u>                             |  |
| 24D. LOCATION (City, town, or county) (State)<br><u>Camden, Del.</u>                                                                                                                                                                                                                                                                                   |  | 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 11 1971</u>                                                                                  |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Fisher, M.D.</u>                                       |  |
| 25C. FUNERAL DIRECTOR<br><u>William B. B. B.</u>                                                                                                                                                                                                                                                                                                       |  | 25D. ADDRESS<br><u>Milford, Del.</u>                                                                                                   |  |                                                                                               |  |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                    |                      |                                                                                                                                                                                                                                |                              | REG. NO. <u>71 10396</u>                                                                     |                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------------------------------------------------------------------------------|------------------------------------------------------------|
| K-655 <u>71 10396</u>                                                                                                                                                                                                                                                                                                                                               |                      | CERTIFICATE OF DEATH                                                                                                                                                                                                           |                              |                                                                                              |                                                            |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                              |                      | 2. DATE AND HOUR OF DEATH                                                                                                                                                                                                      |                              |                                                                                              |                                                            |
| KRENNING, GLADYS SUE                                                                                                                                                                                                                                                                                                                                                |                      | NOVEMBER 8, 1971 1:30 A.M.                                                                                                                                                                                                     |                              |                                                                                              |                                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                              |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                                                                          |                              |                                                                                              |                                                            |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>40 ST AGNES HOSPITAL<br>CATON & WILKENS AVENUE<br>BALTIMORE, MARYLAND 21229                                                                                                                                                                                                                                             |                      | A. STATE<br>MARYLAND<br>B. COUNTY<br>BALTIMORE<br>C. CITY OR TOWN<br>BALTIMORE<br>D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER<br>4128 WILKENS AVENUE |                              |                                                                                              |                                                            |
| 5. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                    | 6. RACE<br>CAUCASIAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                    | 8. DATE OF BIRTH<br>03/17/06 | 9. AGE (In years last birthday)<br>65                                                        | 10. Under 1 Yr. Months Days<br>11 Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE                                                                                                                                                                                                                                                            |                      | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                              |                              | 11. BIRTHPLACE (State or foreign country)<br>VIRGINIA                                        |                                                            |
| 13. FATHER'S NAME<br>COLUMBUS SAIGE                                                                                                                                                                                                                                                                                                                                 |                      | 14. MOTHER'S MAIDEN NAME<br>LILLIE GRUBB                                                                                                                                                                                       |                              | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                       |                                                            |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>no                                                                                                                                                                                                                                                      |                      | 16. SOCIAL SECURITY NO.<br>217-03-8694                                                                                                                                                                                         |                              | 17. INFORMANT<br>BALTO MD 21229<br>ST AGNES' RECORDS CATON & WILKENS AVES                    |                                                            |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                        |                      | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>electrolyte imbalance</u><br>(B) <u>ileostomy</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <u>regional enteritis</u>                           |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>weeks</u><br><u>weeks</u><br><u>years</u> |                                                            |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                              |                      |                                                                                                                                                                                                                                |                              |                                                                                              |                                                            |
| 19A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                                                         |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                               |                              | 20A. AUTOPSY? (Yes or No)<br>NO                                                              |                                                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                               |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                       |                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                     |                                                            |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                           |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                      |                              | 21F. HOW DID INJURY OCCUR?                                                                   |                                                            |
| 22. I certify that (X) (this hospital) attended the deceased from <u>OCTOBER 25</u> 19 <u>71</u> to <u>NOVEMBER 8</u> 19 <u>71</u> that (X) (we) last saw the deceased alive on <u>NOVEMBER 8</u> 19 <u>71</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death. |                      |                                                                                                                                                                                                                                |                              |                                                                                              |                                                            |
| 23A. SIGNATURE<br><u>Charles R. Chaney</u>                                                                                                                                                                                                                                                                                                                          |                      |                                                                                                                                                                                                                                |                              | 23B. DATE SIGNED<br><u>11/8/71</u>                                                           |                                                            |
| 23C. PHYSICIAN'S NAME (Type)<br>CHARLES R. CHANEY, M.D.                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                                                                                                |                              | 23D. ADDRESS<br>BALTO MD 21229<br>ST AGNES HOSPITAL, CATON & WILKENS AVES                    |                                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                  |                      | 24B. DATE<br>Nov. 10, 1971                                                                                                                                                                                                     |                              | 24C. NAME of CEMETERY or CREMATORY<br>New Cathedral Cem.                                     |                                                            |
| 24D. LOCATION (City, town, or county) (State)<br>Balto. Md.                                                                                                                                                                                                                                                                                                         |                      | 25. FUNERAL DIRECTOR<br>G. Truman Schwab 3512 Frederick Ave.                                                                                                                                                                   |                              |                                                                                              |                                                            |

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>WALTER MARKI</b>                                                                                                                                                                                                                                                                                                                                                           |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.                          |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>00 1116 Weldon Ave.</b>                                                                                                                                                                                                                                                                                         |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>11 7 1971 9:15 a.m.</b>                                                        |  |
| 6. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 7. RACE<br><b>white</b>                                                                                                             |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                          |  | C. CITY OR TOWN<br><b>Balto.</b>                                                                                                    |  |
| 9. DATE OF BIRTH<br><b>8/16/1899</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 10. AGE (In years last birthday)<br><b>72</b>                                                                                       |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Poland</b>                                                                                                                                                                                                                                                                                                                                                           |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                          |  |
| 13. FATHER'S NAME<br><b>Jos. Marki</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 14. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>1307</b> |  |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Qtr. Master Corps. U.S. Army</b>                                                                                                                                                                                                                                                                                    |  | 16. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Army</b>                                                                                |  |
| 17. MOTHER'S MAIDEN NAME<br><b>Serafin</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>yes WWI</b>           |  |
| 19. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                              |  | 20. INFORMANT ADDRESS<br><b>Jos. A. Swonder -15 S. Park Ave. -Oil City Pa.</b>                                                      |  |
| 19. CAUSE OF DEATH<br><b>Arteriosclerotic cardiovascular disease</b>                                                                                                                                                                                                                                                                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                        |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                       |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                              |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                       |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                 |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                     |  | (C)                                                                                                                                 |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                               |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                    |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                 |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                            |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                             |  | 22D. TIME OF INJURY (APPROX.)                                                                                                       |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                               |  | 22F. HOW DID INJURY OCCUR?                                                                                                          |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                     |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type) <b>Werner U. Spatz, M.D.</b>                                                                                                                                                                                                                                                                                                                                              |  | DATE SIGNED<br><b>11-8-71</b>                                                                                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                            |  | 24B. DATE<br><b>11/10/71</b>                                                                                                        |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Arlington National</b>                                                                                                                                                                                                                                                                                                                                                      |  | 24D. LOCATION (City, town, or county) (State)<br><b>Arlington, Va.</b>                                                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 11 1971</b>                                                                                                                                                                                                                                                                                                                                                                |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>                                                                             |  |
| 25C. FUNERAL DIRECTOR<br><b>Donovan Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                                 |  | ADDRESS<br><b>-3818 Roland Ave.</b>                                                                                                 |  |



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Wm. K. P.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             |                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           | REG. NO. <b>71 10398</b>                                                                                                                                    |                                                                      |
| E-355 <b>71 10398</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           | CERTIFICATE OF DEATH                                                                                                                                        |                                                                      |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           | 2. DATE AND HOUR OF DEATH                                                                                                                                   |                                                                      |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>EDMONDSTON, ORLANDO B.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           | <b>NOVEMBER 5, 1971 4:25 AM</b>                                                                                                                             |                                                                      |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)                                                                       |                                                                      |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>ST AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           | A. STATE & COUNTY<br><b>MARYLAND Prince Georges</b>                                                                                                         |                                                                      |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           | C. CITY OR TOWN<br><b>LAUREL</b>                                                                                                                            |                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                               |                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | E. STREET AND NUMBER<br><b>502 Talbot Ave.</b>                                                                                                              |                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | HOME WATER LOO RD                                                                                                                                           |                                                                      |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6. RACE<br><b>CAUCASIAN</b>                                                                               | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11/28/86</b>                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CARPENTER</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           | 9. AGE (in years last birthday)<br><b>84</b>                         |
| 13. FATHER'S NAME<br><b>ALEXANDER EDMONDSTON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                                                                                |                                                                      |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                               |                                                                      |
| 16. SOCIAL SECURITY NO.<br><b>216-10-6755</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           | 14. MOTHER'S MAIDEN NAME<br><b>(BOYD) MATILDA</b>                                                                                                           |                                                                      |
| 17. INFORMANT<br><b>RECORD'S BALTIMORE MD 21229</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           | ADDRESS<br><b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>                                                                                                 |                                                                      |
| 18. <b>4-12-31</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>C.M.F.</b>                                                                                                                                                                                                                                                                        |                                                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |                                                                      |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>old M.I. A.S.CVD.</b>                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                                      |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                      |
| 19A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>                                                                                                                     | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |                                                                      |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |                                                                      |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>NOVEMBER 3, 1971</b> to <b>NOVEMBER 5, 1971</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>NOVEMBER 5, 1971</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. |                                                                                                           |                                                                                                                                                             |                                                                      |
| 23A. SIGNATURE<br><b>J. J. Mol.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           | 23B. DATE SIGNED<br><b>11 05 71</b>                                                                                                                         |                                                                      |
| 23C. PHYSICIAN'S NAME (Type)<br><b>J. MOL M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | 23D. ADDRESS<br><b>BALTIMORE MD 21229</b>                                                                                                                   |                                                                      |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           | 24B. DATE<br><b>11/8/71</b>                                                                                                                                 |                                                                      |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Ivy Hill Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           | 24D. LOCATION (City, town, or county) (State)<br><b>Laurel, Prince Georges, Md.</b>                                                                         |                                                                      |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 11 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           | 25B. NAME OF REGISTRAR<br><b>Robert E. Galt, R.D.</b>                                                                                                       |                                                                      |
| 25C. FUNERAL DIRECTOR<br><b>Laurel Funeral Home Inc. 550 Washington Blvd. of Howard M. Fleck Laurel, Md. 20810</b>                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | ADDRESS                                                                                                                                                     |                                                                      |

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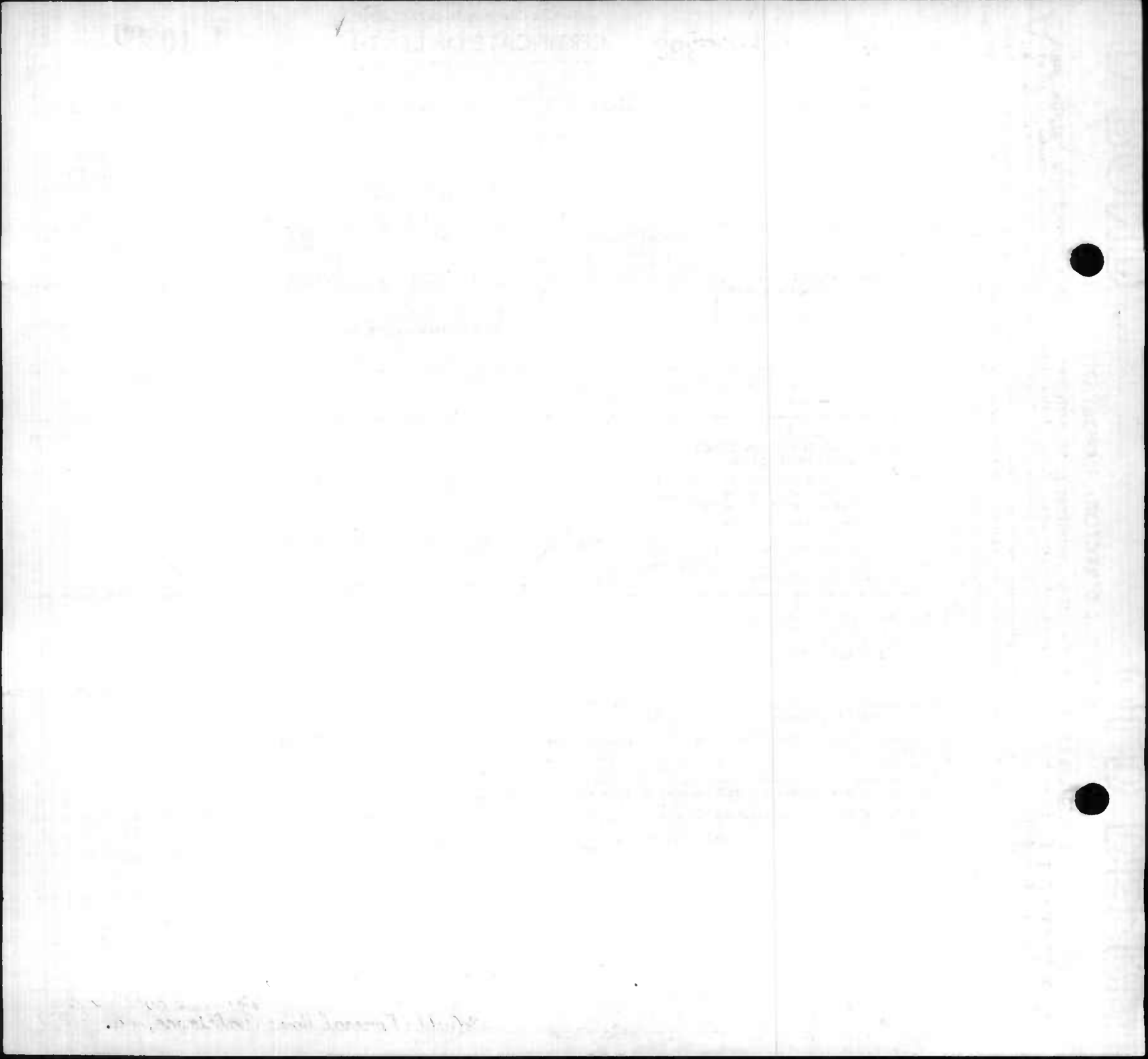
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

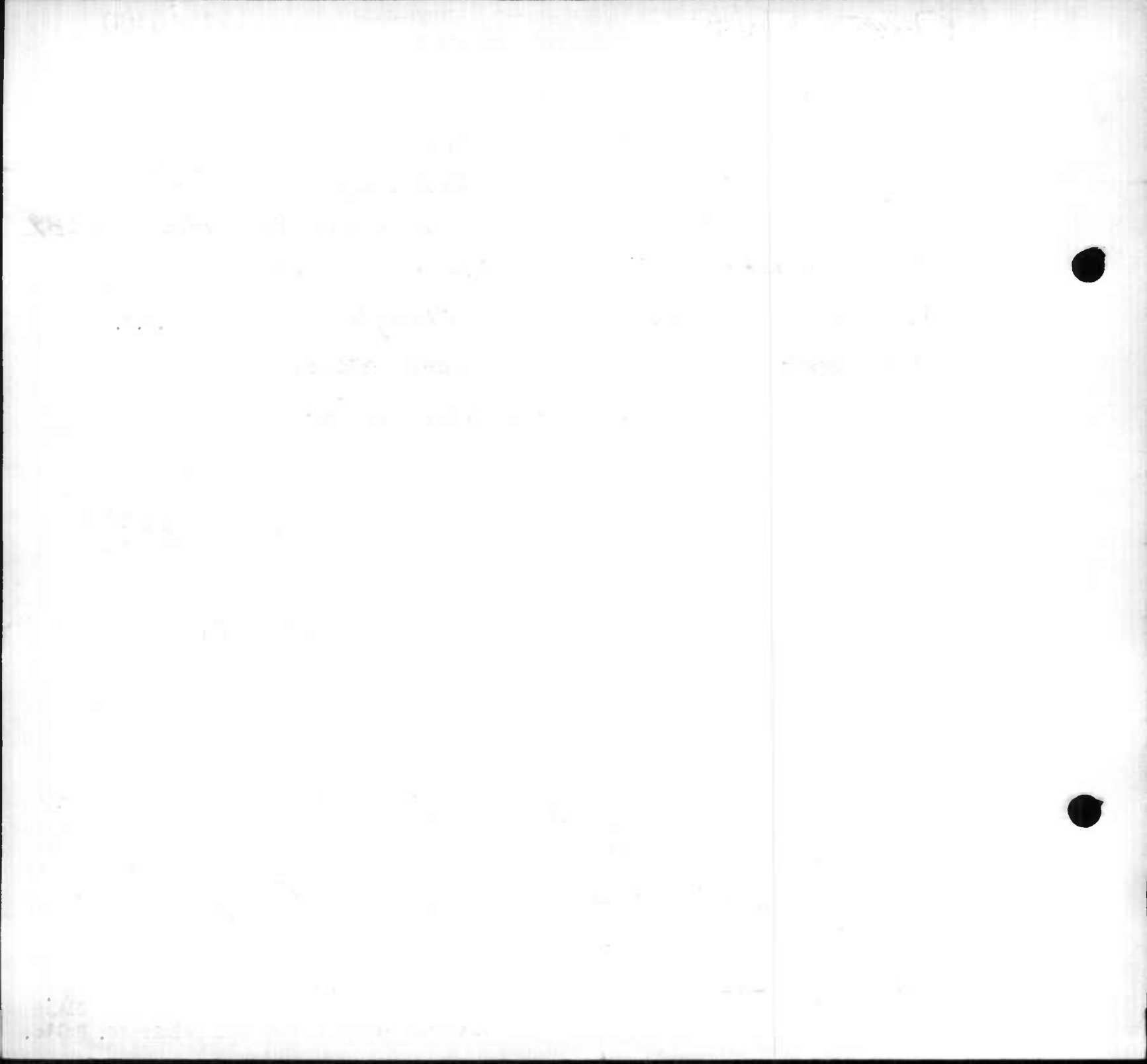
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                             |                            |                                                                                                                                                                                  |                                           | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                        |                                                    | REG. NO. <u>71 10399</u>                                                                                         |                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| <b>1. NAME OF DECEASED</b><br>(Type or Print) <u>Baby boy Spencer</u>                                                                                                                                                                                                                                                                                                                                                                                        |                            |                                                                                                                                                                                  |                                           | <b>2. DATE AND HOUR OF DEATH</b><br><u>11/9/71 7:15 A.M.</u>                                                                                                                                                                                                                                                                |                                                    |                                                                                                                  |                                                                   |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>43 South BAL. General Hospital</u>                                                                                                                                                                                                                                          |                            |                                                                                                                                                                                  |                                           | <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MARYLAND</u> B. COUNTY <u>701</u><br>C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>924 N. Streetor</u> |                                                    |                                                                                                                  |                                                                   |
| <b>5. SEX</b><br><u>M</u>                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>6. RACE</b><br><u>W</u> | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>11/9/71</u> |                                                                                                                                                                                                                                                                                                                             | <b>9. AGE</b> (In years last birthday)<br><u>3</u> | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>NONE</u> | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>U.S.A.</u> |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>NONE</u>                                                                                                                                                                                                                                                                                                                                            |                            | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br>                                                                                                                                     |                                           | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.</u>                                                                                                                                                                                                                                                                          |                                                    |                                                                                                                  |                                                                   |
| <b>13. FATHER'S NAME</b><br>                                                                                                                                                                                                                                                                                                                                                                                                                                 |                            |                                                                                                                                                                                  |                                           | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Elizabeth Spencer</u>                                                                                                                                                                                                                                                                 |                                                    |                                                                                                                  |                                                                   |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br>                                                                                                                                                                                                                                                                                                                                          |                            | <b>16. SOCIAL SECURITY NO.</b><br>                                                                                                                                               |                                           | <b>17. INFORMANT</b><br><u>Chad</u>                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                  |                                                                   |
| <b>18. CAUSE OF DEATH</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>775.01 Hemolytic anemia of newborn</u><br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>due to Rh incompatibility</u> |                            |                                                                                                                                                                                  |                                           | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><u>3 hours 25 min</u>                                                                                                                                                                                                                                                |                                                    |                                                                                                                  |                                                                   |
| <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>                                                                                                                                                                                                                                                                                                                      |                            |                                                                                                                                                                                  |                                           |                                                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                  |                                                                   |
| <b>19A. DATE OF OPERATION</b><br>                                                                                                                                                                                                                                                                                                                                                                                                                            |                            | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br>                                                                                                                      |                                           | <b>20A. AUTOPSY?</b> (Yes or No)                                                                                                                                                                                                                                                                                            |                                                    | <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>                                      |                                                                   |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                 |                            | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                  |                                           | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)                                                                                                                                                                                                                                             |                                                    |                                                                                                                  |                                                                   |
| <b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                             |                            | <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                    |                                           | <b>21F. HOW DID INJURY OCCUR?</b>                                                                                                                                                                                                                                                                                           |                                                    |                                                                                                                  |                                                                   |
| <b>22. I certify that (I) (this hospital) attended the deceased from <u>11/9 3:50 AM</u> <u>1971</u> to <u>11/9 7:15 AM</u> <u>1971</u> that (I) (we) lost saw the deceased alive on <u>11/9 7:15 AM</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>                                                                            |                            |                                                                                                                                                                                  |                                           |                                                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                  |                                                                   |
| <b>23A. SIGNATURE</b><br><u>GRGIC</u> M.D.                                                                                                                                                                                                                                                                                                                                                                                                                   |                            |                                                                                                                                                                                  |                                           | <b>23B. DATE SIGNED</b><br><u>11/9 71</u>                                                                                                                                                                                                                                                                                   |                                                    | <b>23C. PHYSICIAN'S NAME</b> (Type)<br>                                                                          |                                                                   |
| <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                             |                            |                                                                                                                                                                                  |                                           | <b>24B. DATE</b><br><u>10-10-71</u>                                                                                                                                                                                                                                                                                         |                                                    | <b>24C. NAME OF CEMETERY OR CREMATORY</b><br><u>St. Peters Cemetery</u>                                          |                                                                   |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br><u>Baltimore, Maryland</u>                                                                                                                                                                                                                                                                                                                                                                           |                            |                                                                                                                                                                                  |                                           | <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><u>NOV 11 1971</u>                                                                                                                                                                                                                                                                |                                                    |                                                                                                                  |                                                                   |
| <b>25B. NAME OF REGISTRAR</b><br><u>Robert E. Taylor, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                               |                            |                                                                                                                                                                                  |                                           | <b>25C. FUNERAL DIRECTOR</b><br><u>130 East Baltimore Ave. Baltimore, Md. 21230</u>                                                                                                                                                                                                                                         |                                                    |                                                                                                                  |                                                                   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

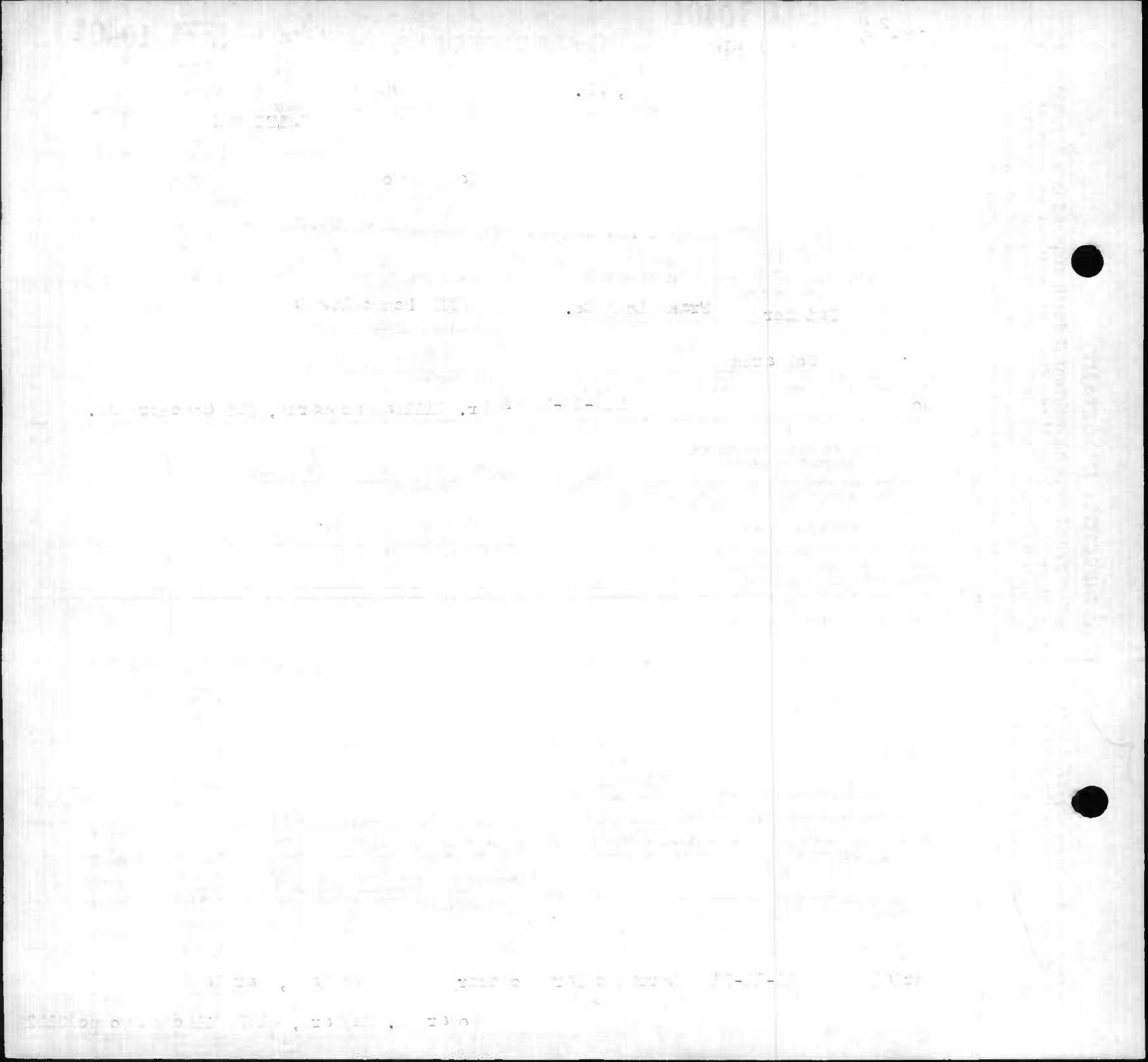
|                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                             |  |                                                                                                                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 0-645 71 10400                                                                                                                                                                                                                                                                                                                                                  |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                            |  | 71 10400                                                                                                                                                    |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                       |  | CERTIFICATE OF DEATH                                                                                                                                                                                        |  | REG. NO.                                                                                                                                                    |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Orelando Doka L.</u>                                                                                                                                                                                                                                                                                                  |  | 2. DATE AND HOUR OF DEATH<br><u>11-8-71 11:13 P.M.</u>                                                                                                                                                      |  |                                                                                                                                                             |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Bolton Hill Nsg. Home</u>                                                                                                                                                         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)<br>A. STATE <u>Md.</u> B. COUNTY <u>2739</u>                                                                           |  |                                                                                                                                                             |  |
| 5. SEX <u>F</u>                                                                                                                                                                                                                                                                                                                                                 |  | 6. RACE <u>White</u>                                                                                                                                                                                        |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH <u>4/2/02</u>                                                                                                                                                                                                                                                                                                                                  |  | 9. AGE (In years last birthday) <u>69</u>                                                                                                                                                                   |  | 10. UNDER 1 Yr. Months Days<br>11. UNDER 24 Hrs. Hours Min.                                                                                                 |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                                                                                                                                 |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Homekeeping</u>                                                                                                                                                     |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                                                                                |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                                                                                                                                                                                                   |  | 13. FATHER'S NAME<br><u>Joseph Bonomo</u>                                                                                                                                                                   |  | 14. MOTHER'S MAIDEN NAME<br><u>Carmela Poligaro</u>                                                                                                         |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                           |  | 16. SOCIAL SECURITY NO.<br><u>214-14-0668</u>                                                                                                                                                               |  | 17. INFORMANT<br><u>Medical Record</u>                                                                                                                      |  |
| 18. <u>410.9 + 250.9</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Coronary Artery - MI</u><br>(B) <u>A.S. C. V. Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <u>Diabetes Mellitus</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>?</u>                                                                                   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                          |  |                                                                                                                                                                                                             |  |                                                                                                                                                             |  |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                              |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                            |  | 20A. AUTOPSY (Yes or No)<br><u>No</u>                                                                                                                       |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                            |  | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                     |  |                                                                                                                                                             |  |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                        |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                    |  |                                                                                                                                                             |  |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                       |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                   |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased, from <u>8/4</u> 19 <u>69</u> to <u>11-8</u> 19 <u>71</u><br>that (I) (we) last saw the deceased alive on <u>11/6</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.        |  |                                                                                                                                                                                                             |  |                                                                                                                                                             |  |
| 23A. SIGNATURE<br><u>Joseph S. Bell</u>                                                                                                                                                                                                                                                                                                                         |  | 23B. DATE SIGNED<br><u>11/8/71</u>                                                                                                                                                                          |  | 23C. PHYSICIAN'S NAME (Type)<br><u>JOSEPH S. BELL</u>                                                                                                       |  |
| 23D. ADDRESS<br><u>1105 N CALVERT ST</u>                                                                                                                                                                                                                                                                                                                        |  | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                   |  |                                                                                                                                                             |  |
| 24B. DATE<br><u>11-12-71</u>                                                                                                                                                                                                                                                                                                                                    |  | 24C. NAME of CEMETERY or CREMATORY<br><u>Most Holy Redeemer Cemetery</u>                                                                                                                                    |  | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore Md.</u>                                                                                       |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 11 1971</u>                                                                                                                                                                                                                                                                                                           |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, M.D.</u>                                                                                                                                                     |  | 25C. FUNERAL DIRECTOR<br><u>Lassahn Funeral Home</u>                                                                                                        |  |
| 25D. ADDRESS<br><u>7401 Belair Rd. Balto.</u>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                             |  |                                                                                                                                                             |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                     |                                                                                                                                                                                         |                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--|
| <div style="display: flex; justify-content: space-between;"> <span><b>S-632</b></span> <span><b>71 10401</b></span> </div>                                                                                                                                                                                                                                                  |  | <b>BALTIMORE CITY HEALTH DEPARTMENT</b><br><b>CERTIFICATE OF DEATH</b>              |                                                                                                                                                                                         | <b>REG. NO. 71 10401</b>                                                   |  |
| <b>BIRTH NO.</b> <i>Charles A. Schwartz</i>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                     | <b>2. DATE AND HOUR OF DEATH</b><br><i>11-7-71 at 8:50 PM</i>                                                                                                                           |                                                                            |  |
| <b>1. NAME OF DECEASED</b><br>(Type or Print) <i>Charles A. Schwartz, SR.</i>                                                                                                                                                                                                                                                                                               |  |                                                                                     | <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>                                                                                                                           |                                                                            |  |
| <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>BALTIMORE</i><br>B. COUNTY <i>BALTIMORE</i><br><i>217 Hazel Ave. Lonsdowne, Maryland.</i>                                                                                                                                                                       |  |                                                                                     | <b>5. SEX</b><br><i>Male</i>                                                                                                                                                            |                                                                            |  |
| <b>6. RACE</b><br><i>White</i>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                     | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |                                                                            |  |
| <b>8. DATE OF BIRTH</b><br><i>6-13-92</i>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                     | <b>9. AGE</b> (In years last birthday) <i>79</i>                                                                                                                                        |                                                                            |  |
| <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><i>Retired Painter</i>                                                                                                                                                                                                                                                 |  |                                                                                     | <b>11. BIRTHPLACE</b> (State or foreign country)<br><i>Pennsylvania</i>                                                                                                                 |                                                                            |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><i>USA</i>                                                                                                                                                                                                                                                                                                                           |  |                                                                                     | <b>13. FATHER'S NAME</b><br><i>John Schwartz</i>                                                                                                                                        |                                                                            |  |
| <b>14. MOTHER'S MAIDEN NAME</b><br><i>Susan Smizer</i>                                                                                                                                                                                                                                                                                                                      |  |                                                                                     | <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>                                                         |                                                                            |  |
| <b>16. SOCIAL SECURITY NO.</b><br><i>218-10-2989A</i>                                                                                                                                                                                                                                                                                                                       |  |                                                                                     | <b>17. INFORMANT</b><br><i>Mr. William Schwartz, 529 Coventry Rd.</i>                                                                                                                   |                                                                            |  |
| <b>18. CAUSE OF DEATH</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |                                                                                     | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>                                                                                                                                     |                                                                            |  |
| <b>(A) IMMEDIATE CAUSE</b><br><i>Respiratory Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                 |  |                                                                                     | <b>(B) CHRONIC DISEASE, DEHYDRATION, CHF</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                         |                                                                            |  |
| <b>(C)</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                     | <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>                                                 |                                                                            |  |
| <b>19A. DATE OF OPERATION</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                     | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>                                                                                                                                 |                                                                            |  |
| <b>20A. AUTOPSY?</b> (Yes or No)                                                                                                                                                                                                                                                                                                                                            |  |                                                                                     | <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>                                                                                                             |                                                                            |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Indicate medical examination)                                                                                                                                                                                                                                                                           |  |                                                                                     | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                         |                                                                            |  |
| <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                             |  |                                                                                     | <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                        |                                                                            |  |
| <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                            |  |                                                                                     | <b>21F. HOW DID INJURY OCCUR?</b>                                                                                                                                                       |                                                                            |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from <i>10-31-1971</i> to <i>11-7-1971</i> that (I) (we) last saw the deceased alive on <i>11-7-1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>                                       |  |                                                                                     |                                                                                                                                                                                         |                                                                            |  |
| <b>23A. SIGNATURE</b><br><i>Want</i>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                     | <b>23B. DATE SIGNED</b><br><i>Nov. 7, 1971</i>                                                                                                                                          |                                                                            |  |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br><i>Want (NAVAL CAPT) M.D.</i>                                                                                                                                                                                                                                                                                                        |  |                                                                                     | <b>23D. ADDRESS</b>                                                                                                                                                                     |                                                                            |  |
| <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                            |  | <b>24B. DATE</b><br><i>11-11-71</i>                                                 |                                                                                                                                                                                         | <b>24C. NAME OF CEMETERY or CREMATORY</b><br><i>Lorraine Park Cemetery</i> |  |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br><i>Woodlawn, Maryland</i>                                                                                                                                                                                                                                                                                           |  | <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><i>NOV 11 1971</i>                        |                                                                                                                                                                                         |                                                                            |  |
| <b>25B. NAME OF REGISTRAR</b><br><i>Robert E. Taylor, M.D.</i>                                                                                                                                                                                                                                                                                                              |  | <b>25C. FUNERAL DIRECTOR</b><br><i>Howard H. Hubbard, 4107 Wilkens Avenue 21229</i> |                                                                                                                                                                                         |                                                                            |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                             | REG. NO. 71 10402                                                                                  |                                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| P-120 71 10402                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                             | BIRTH NO.                                                                                          |                                                                          |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ERNEST EUGENE PHEBUS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>NOVEMBER 8 1971 4:50 A. M.</b>                                                                                                                                                                                                                                                                                              |                                                                                                    |                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>ST AGNES HOSPITAL</b><br><b>40</b>                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE COUNTY</b><br>C. CITY OR TOWN <b>XXXXXXXXXX ARBUTUS</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER<br><b>1051 MAIDEN CHOICE LANE 21229</b> |                                                                                                    |                                                                          |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 6. RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>01/28/92</b>                                                                                                                                                                                                                                                                                                                         | 9. AGE (In years last birthday)<br><b>79</b>                                                       | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED PLASTERER</b>                                                                                                                                                                                                                                                                                                                                                                                        |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                       |                                                                          |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 13. FATHER'S NAME<br><b>JOSEPH PHEBUS DEC'D</b>                                                                                                             |                                                                                                                                                                                                                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>(HOWELL) MARY DEC'D</b>                                             |                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                          |                         | 16. SOCIAL SECURITY NO.<br><b>216 10 1574</b>                                                                                                               |                                                                                                                                                                                                                                                                                                                                                             | 17. INFORMANT<br><b>RECORD'S BALTIMORE ADDRESS 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b> |                                                                          |
| 18. <b>427.0 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                         |                                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <i>Emphysema and</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Chronic Bronchitis with Pulmonary Fibrosis.</i><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><i>Congestive Heart Failure</i><br>(C)                                                                                                                        |                                                                                                    |                                                                          |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                            |                                                                                                    | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                                                                                                                                                                                                                     |                                                                                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                      |                                                                                                    | 21F. HOW DID INJURY OCCUR?                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 3, 19 71</b> to <b>NOVEMBER 8, 19 71</b> that (I) (we) last saw the deceased alive on <b>NOVEMBER 8, 19 71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                          |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                             |                                                                                                    |                                                                          |
| 23A. SIGNATURE<br><i>M. Yousuf Siddiqui</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             | 23B. DATE SIGNED<br><b>11/08/71</b>                                                                                                                                                                                                                                                                                                                         |                                                                                                    | 23C. PHYSICIAN'S NAME (Type)<br><b>M. YOUSUF SIDDIQUI, M.D.</b>          |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             | 24B. DATE<br><b>11-11-71</b>                                                                                                                                                                                                                                                                                                                                |                                                                                                    | 24C. NAME of CEMETERY or CREMATORY<br><b>Lorraine Park Cemetery</b>      |
| 24D. LOCATION (City, town, or county) (State)<br><b>Woodlawn, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 11 1971</b>                                                                                                                                                                                                                                                                                                       |                                                                                                    |                                                                          |
| 25B. NAME OF REGISTRAR<br><i>Robert E. ...</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | 25C. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>                                                                                                                                                                                                                                                                                  |                                                                                                    |                                                                          |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print)<br><b>John Seibert</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month <b>11</b> Day <b>8</b> Year <b>71</b><br>Estimated <input type="checkbox"/> <b>6:30 P. M.</b> |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>40 St. Agnes Hospital</b><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 3. DATE PRONOUNCED DEAD<br>Month <b>11</b> Day <b>8</b> Year <b>71</b><br><b>6:30 P. M.</b>                                                                       |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 7. RACE<br><b>White</b>                                                                                                                                           |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                               |  |
| 9. DATE OF BIRTH<br><b>10-14-1912</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10. AGE (In years last birthday)<br><b>59</b>                                                                                                                     |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                     |  |
| 13. FATHER'S NAME<br><b>Carl H. Seibert</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>                     |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Coralee Downing</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | E. STREET AND NUMBER<br><b>1201 Locust Avenue</b>                                                                                                                 |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 17. SOCIAL SECURITY NO.<br><b>577-03-6843</b>                                                                                                                     |  |
| 18. INFORMANT<br><b>Mrs. Matilda E. Seibert, 1201 Locust Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | ADDRESS<br><b>21227</b>                                                                                                                                           |  |
| 19. <b>412.4 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>disease</b>                                                                                                                                                                                                                                                                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                      |  |
| 20. DATE OF OPERATION<br><b>11-12-1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 21. AUTOPSY? (Yes or No)<br><b>No</b>                                                                                                                             |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                          |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)                                                                                                |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 22F. HOW DID INJURY OCCUR?                                                                                                                                        |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D.<br>EXAMINER'S NAME (Type) |  |                                                                                                                                                                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 24B. DATE<br><b>11-12-1971</b>                                                                                                                                    |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Loudon Park Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                                                                                       |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 11 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>                                                                                                           |  |
| 25C. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | ADDRESS                                                                                                                                                           |  |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Wilma W. Barber

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

3-30-23

9. AGE (in years  
last birthday)

48

If Under 1 Yr.  
Months: DaysIf Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Marion H. Arrwood

14. MOTHER'S MAIDEN NAME

Nellie Cubertson

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

247 28 1227

17. INFORMANT

BCH RECORDS: 4940 Eastern Avenue  
Baltimore, Maryland 2122418. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-18-71 1971 to 11-7-71 1971  
that (I) (we) last saw the deceased alive on 11-6-71 1971 and that (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Larry Kvals, M.D.

DEGREE

Attending  
Phys.Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

11-7-71

23C. PHYSICIAN'S  
NAME (Type)

LARRY KVALS, M.D.

DEGREE

23D. ADDRESS Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

11 10 71

24C. NAME of CEMETERY or CREMATORY

Oak Grove Cemetery

24D. LOCATION

(City, town, or county)

(State)

Morganton Berke Co., N. Carolina

25A. DATE REC'D BY HEALTH DEPT.

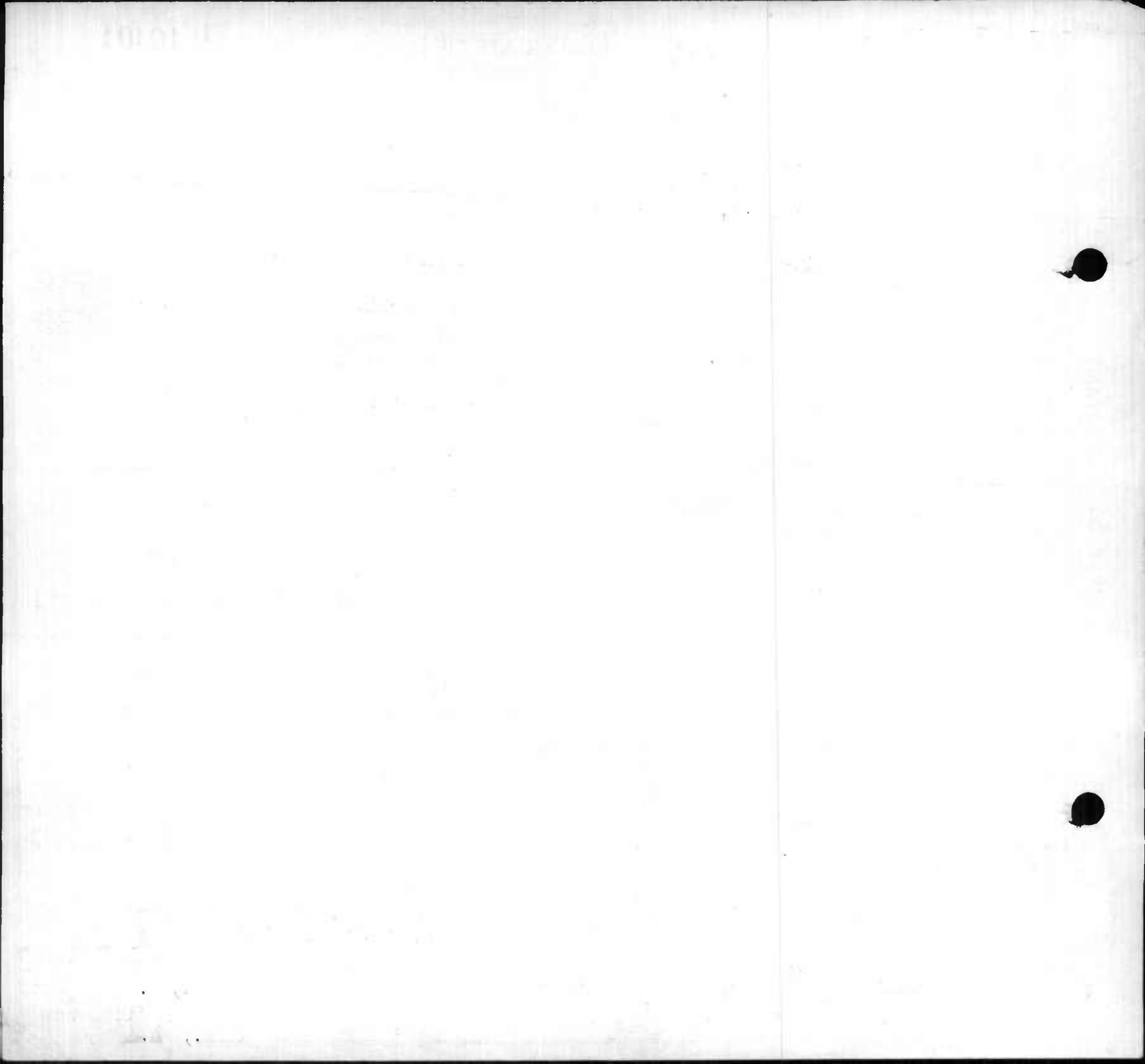
NOV 11 1971

25B. NAME OF REGISTRAR

Vesley E. Fisher, M.D.

25C. FUNERAL DIRECTOR

McGuffy Funeral Home 130 East Fort Avenue  
Balto., Md. 21230





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                  |                                                                                                                                                                                                                                                                                        | 71 10405<br>REG. NO.                            |                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------|
| BIRTH NO.<br>W-514 71 10405                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  | 1. NAME OF DECEASED<br>(Type or Print) MINNIE WOMBLE                                                                                             |                                                                                                                                                                                                                                                                                        | 2. DATE AND HOUR OF DEATH<br>11/8/71 4:05 P. M. |                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Lutheran Hospital of Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE md. B. COUNTY 1503<br>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 1611 N. Bentall St |                                                 |                                                             |
| 5. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 6. RACE<br>Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>2-3-95                                                                                                                                                                                                                                                             | 9. AGE (In years last birthday)<br>76           | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Domestic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Pvt. Family                                                                                                 | 11. BIRTHPLACE (State or foreign country)<br>Virginia                                                                                                                                                                                                                                  |                                                 | 12. CITIZEN OF WHAT COUNTRY?<br>USA                         |
| 13. FATHER'S NAME<br>Elam Collins                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                  | 14. MOTHER'S MAIDEN NAME<br>Amanda McCargo                                                                                                                                                                                                                                             |                                                 |                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 16. SOCIAL SECURITY NO.<br>287-18-9021                                                                                                           | 17. INFORMANT<br>Mr. John McCargo 1611 N. Bentall St                                                                                                                                                                                                                                   |                                                 |                                                             |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>19A. DATE OF OPERATION<br>11/8/71<br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Fracture of femur<br>20A. AUTOPSY? (Yes or No)<br>YES<br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                  |                                                                                                                                                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Atherosclerotic heart disease<br>(B) Fracture neck of left femur<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Trauma<br>(C) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |                                                 |                                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>None                                                                                                                                                                                       |                                                 |                                                             |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br>10-30-71 ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>                                                                                                                                                                   |                                                 |                                                             |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>1611 N Bentall St                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                  | 21F. HOW DID INJURY OCCUR?<br>Fall                                                                                                                                                                                                                                                     |                                                 |                                                             |
| 22. I certify that (I) (this hospital) attended the deceased from 10/30/1971 to 11/8/1971 that (I) (we) last saw the deceased alive on 11/8/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                                  |                                                                                                                                                                                                                                                                                        |                                                 |                                                             |
| 23A. SIGNATURE<br>S. Basu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                                  | 23B. DATE SIGNED<br>11/8/71                                                                                                                                                                                                                                                            |                                                 | 23C. PHYSICIAN'S NAME (Type)<br>S. BASU                     |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                  | 24B. DATE<br>11-11-71                                                                                                                                                                                                                                                                  |                                                 | 24C. NAME of CEMETERY or CREMATORY<br>Arbutus Memorial Park |
| 24D. LOCATION<br>Baltimore Co. Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                  | 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 11 1971                                                                                                                                                                                                                                         |                                                 |                                                             |
| 25B. NAME OF REGISTRAR<br>E. E. E.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                  | 25C. FUNERAL DIRECTOR<br>NUTTER FUNERAL HOME 3035 W. NORTH AVE.                                                                                                                                                                                                                        |                                                 |                                                             |





BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO. <u>L-625</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | REG. NO. <u>71 10406</u>                                                                                                                                              |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><u>Clara Larkins</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month <u>11</u> Day <u>9</u> Year <u>71</u> Hour <u>7:35</u> A.M.<br>Estimated <input type="checkbox"/> |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><u>42 Sinai Hospital</u><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 3. DATE PRONOUNCED DEAD<br>Month <u>11</u> Day <u>9</u> Year <u>71</u> Hour <u>7:35</u> A.M.                                                                          |  |
| 6. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 7. RACE<br><u>Negro</u>                                                                                                                                               |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                                   |  |
| 9. DATE OF BIRTH<br><u>2-3-1894</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                         |  |
| 10. AGE (In years last birthday)<br><u>77</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | E. STREET AND NUMBER<br><u>3800 Howard Street</u>                                                                                                                     |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                                                            |  |
| 13. FATHER'S NAME<br><u>James Woolford</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                        |  |
| 15. MOTHER'S MAIDEN NAME<br><u>Eleanor Curtis</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                  |  |
| 17. SOCIAL SECURITY NO.<br><u>214-14-9457</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 18. INFORMANT<br><u>Mrs. Clara Bailey</u>                                                                                                                             |  |
| 19. <u>412.21</u><br>CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | ADDRESS<br><u>3800 Howard Park Ave</u>                                                                                                                                |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                          |  |
| 20A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                      |  |
| 21. AUTOPSY? (Yes or No)<br><u>No</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                       |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)                                                                              |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                       |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                |  |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                       |  |
| 23.<br>I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <u>Werner U. Spitz</u> M.D.<br>EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u> |  |                                                                                                                                                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 24B. DATE<br><u>11-15-1971</u>                                                                                                                                        |  |
| 24C. NAME of CEMETERY or CREMATORY<br><u>Baltimore National Cem</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore Maryland</u>                                                                                            |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 11 1971</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Gables</u>                                                                                                                     |  |
| 25C. FUNERAL DIRECTOR<br><u>NUTTER FUNERAL HOME</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | ADDRESS<br><u>3035 W. NORTH AVE</u>                                                                                                                                   |  |

3800 Howard Park Ave

2070 15

ADRIAN W. BROWN

1945-1946

1947-1948

1949-1950

1951-1952

1953-1954

1955-1956

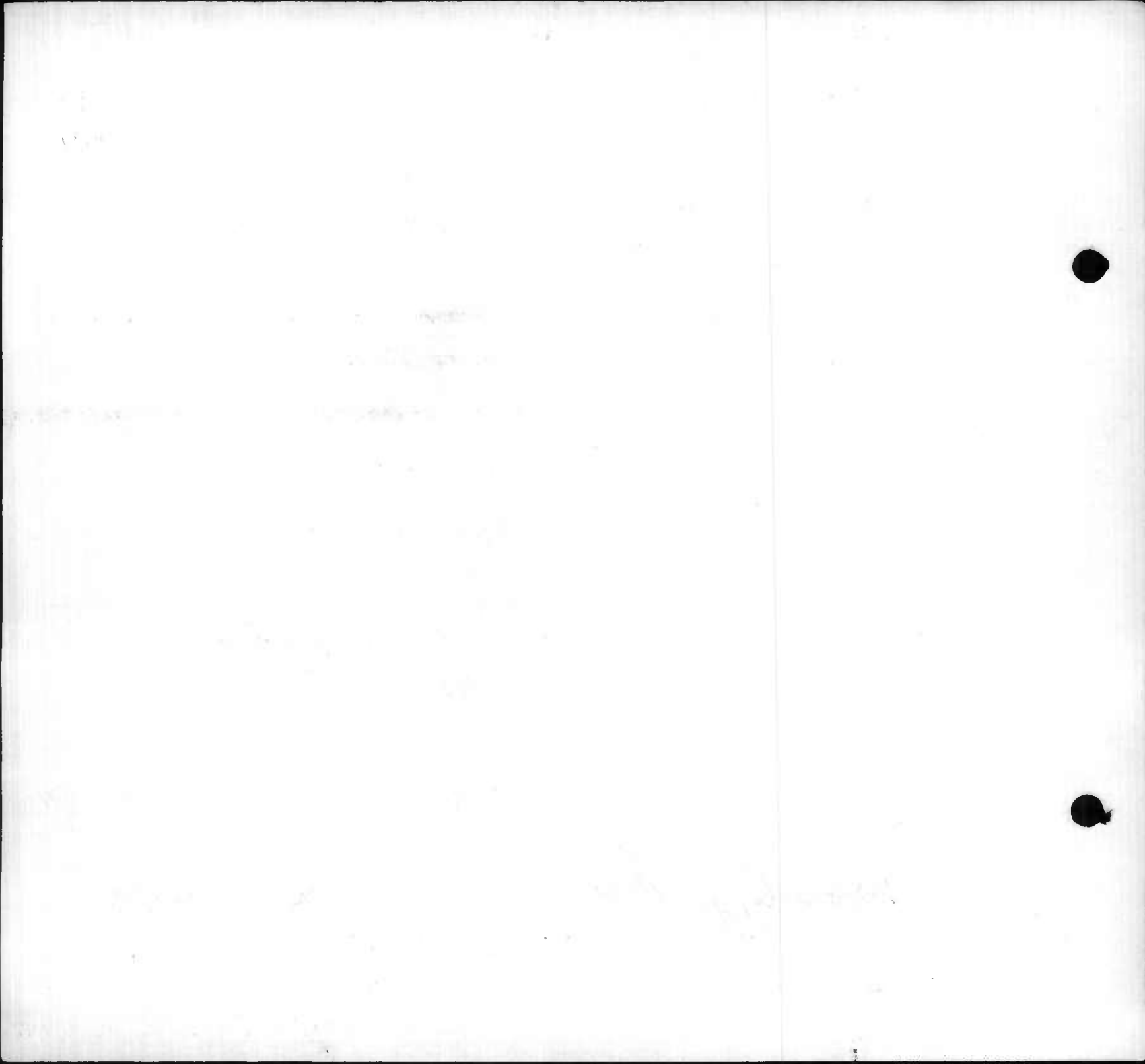
1957-1958

1959-1960

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

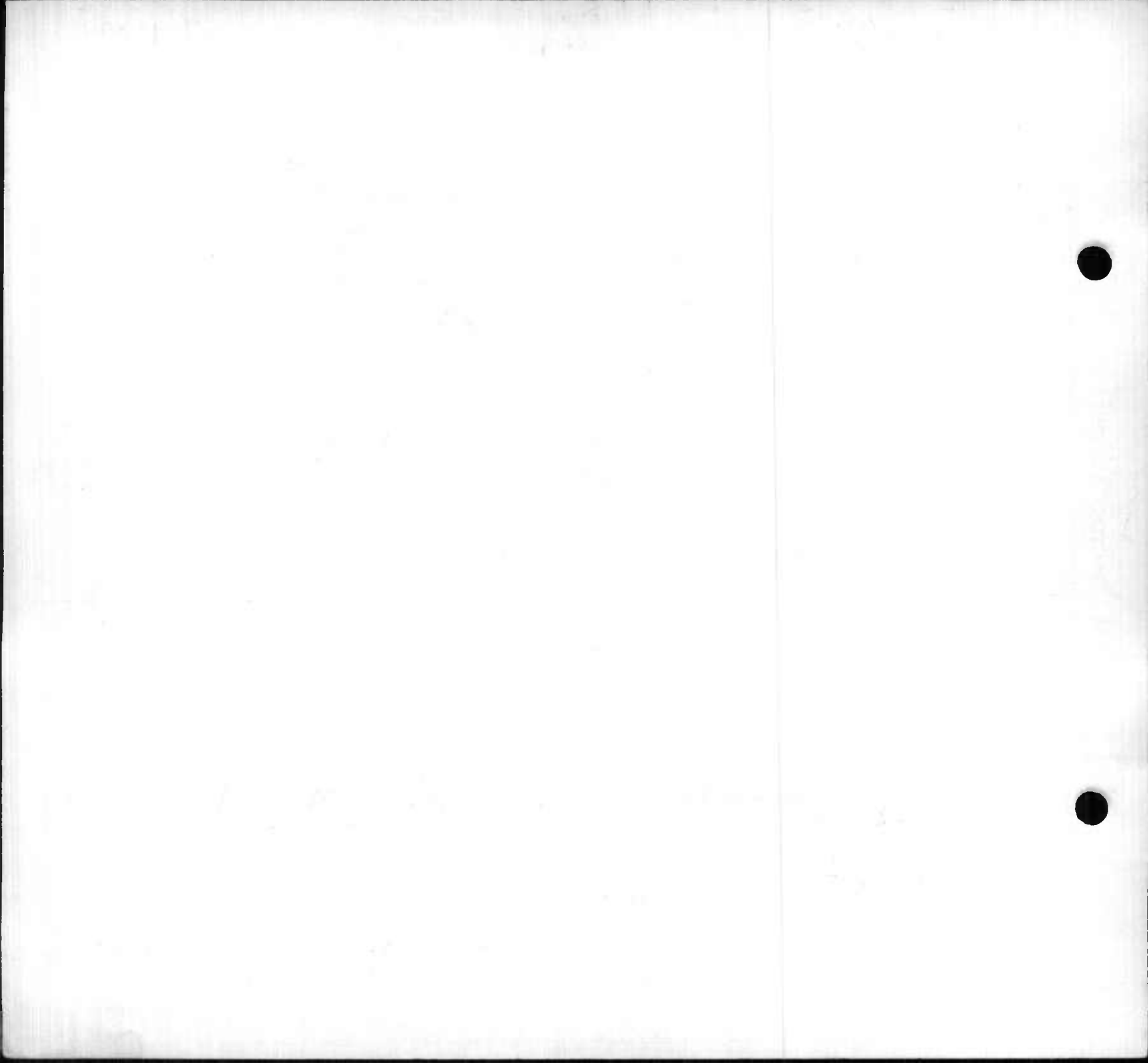
| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                                                                                                                                                                                          | REG. NO. <u>71 10407</u>                                                              |                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| BIRTH NO. <u>B-620 71 10407</u>                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                                                                                                                                                                                          |                                                                                       |                                                                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Mr. Wayman Breeze</u>                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><u>November 9, 1971</u> <u>8:20a</u> M.                                                                                                                                     |                                                                                       |                                                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>KESWICK (Home for Incurables)</u>                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>1601</u>                                                                |                                                                                       |                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                                                                      |                                                                                       | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | E. STREET AND NUMBER<br><u>1011 Edmondson Avenue</u>                                                                                                                                                     |                                                                                       |                                                                                               |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                                                                                                                                                 | 6. RACE<br><u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>12/30/1891</u>                                                                                                                                                                    | 9. AGE (in years last birthday)<br><u>79</u>                                          | 10. Under 1 Yr. Months Days<br>11. Under 24 Hrs. Hours Min.                                   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Janitor</u>                                                                                                                                                                                                                                                                                                                         |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>U. S. O.</u>                                                                                                        | 11. BIRTHPLACE (State or foreign country)<br><u>Easton Shore, Md.</u>                                                                                                                                    |                                                                                       | 12. CITIZEN OF WHAT COUNTRY<br><u>U. S. A.</u>                                                |
| 13. FATHER'S NAME<br><u>Charles W. Breeze</u>                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><u>Emma Miller</u>                                                                                                                                                           |                                                                                       |                                                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>yes</u> <u>WW-I</u>                                                                                                                                                                                                                                                                                                    |                         | 16. SOCIAL SECURITY NO.<br><u>213-16-5845</u>                                                                                                               | 17. INFORMANT<br><u>Mrs. Areita Daniel</u> ADDRESS <u>715 N. Payson Street</u>                                                                                                                           |                                                                                       |                                                                                               |
| 18. <u>431.9 14/85X</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>Intracerebral hemorrhage</u><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>Generalized arteriosclerosis</u> |                         |                                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Generalized arteriosclerosis</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><u>Adenocarcinoma of prostate</u><br>(C) _____ |                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 minute</u><br><u>Many years</u>          |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><u>II</u>                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             |                                                                                                                                                                                                          |                                                                                       |                                                                                               |
| 19A. DATE OF OPERATION<br><u>11/9/71</u>                                                                                                                                                                                                                                                                                                                                                                                              |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>NO</u>                                                                                               |                                                                                                                                                                                                          | 20A. AUTOPSY? (Yes or No)<br><u>NO</u>                                                |                                                                                               |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                                                                                                                                                                                          |                                                                                       |                                                                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                     |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                                                                                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                             |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                          | 21F. HOW DID INJURY OCCUR?                                                            |                                                                                               |
| 22. I certify that (1) (this hospital) attended the deceased from <u>September 20</u> 19 <u>71</u> to <u>November 9</u> 19 <u>71</u> that (2) (we) last saw the deceased alive on <u>Nov 9</u> 19 <u>71</u> and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) (did not) view the body after death.                                                     |                         |                                                                                                                                                             |                                                                                                                                                                                                          |                                                                                       |                                                                                               |
| 23A. SIGNATURE<br><u>W.B. Daniels, Jr. M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 23B. DATE SIGNED<br><u>11/9/71</u>                                                                                                                                                                       |                                                                                       |                                                                                               |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Worth B. Daniels, Jr. M.D.</u>                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 23D. ADDRESS<br><u>700 W. 40th Street #21211</u>                                                                                                                                                         |                                                                                       |                                                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                             |                         | 24B. DATE<br><u>11-12-71</u>                                                                                                                                |                                                                                                                                                                                                          | 24C. NAME OF CEMETERY or CREMATORY<br><u>Arbutus Memorial Park</u>                    |                                                                                               |
| 24D. LOCATION<br><u>Baltimore</u>                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 24E. COUNTY<br><u>Co.</u>                                                                                                                                   |                                                                                                                                                                                                          | 24F. STATE<br><u>Maryland</u>                                                         |                                                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 11 1971</u>                                                                                                                                                                                                                                                                                                                                                                                 |                         | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, M.D.</u>                                                                                                     |                                                                                                                                                                                                          | 25C. FUNERAL DIRECTOR<br><u>NUTTER FUNERAL HOME</u> ADDRESS <u>3035 W. NORTH AVE.</u> |                                                                                               |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

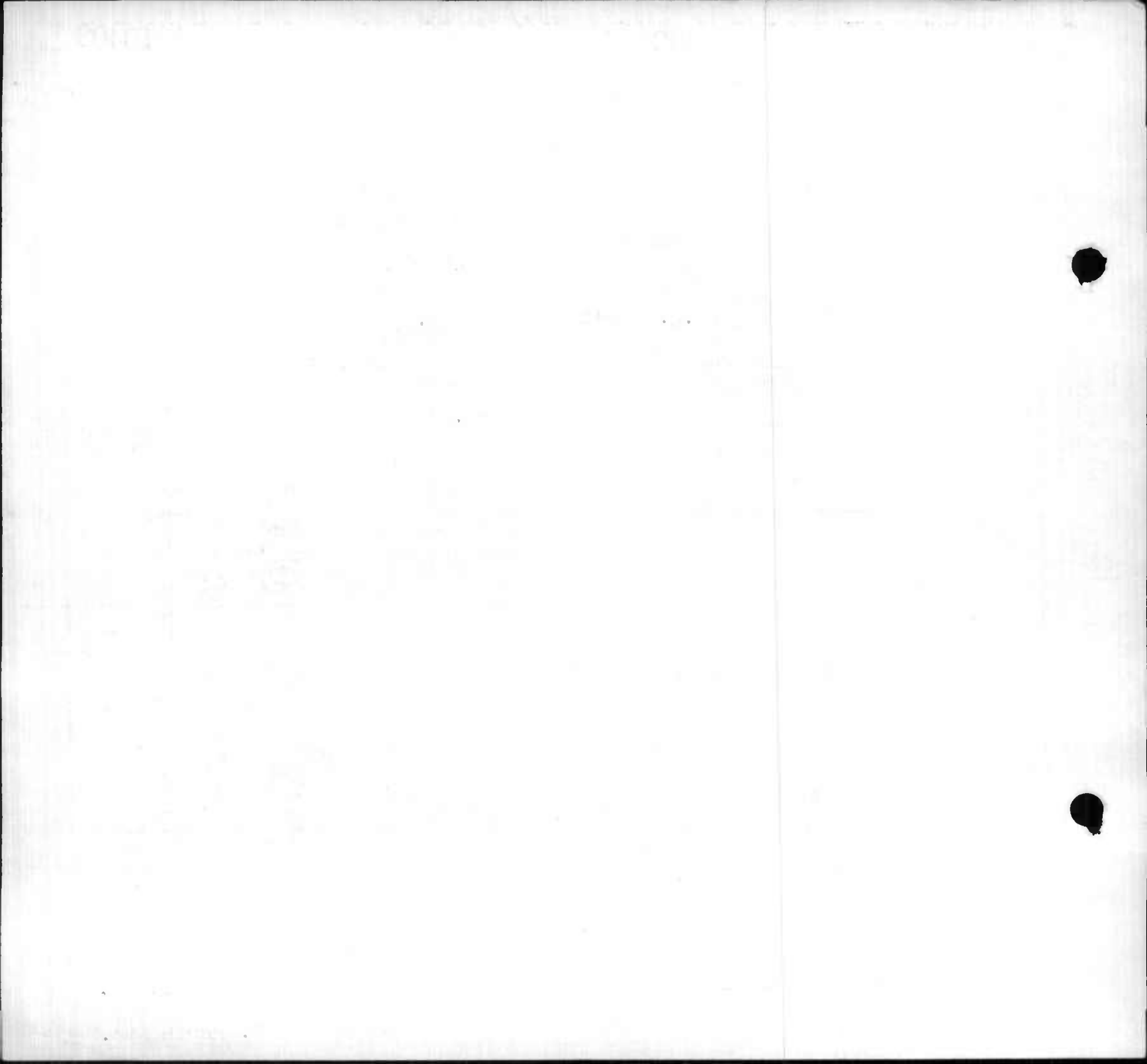
|                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>BALTIMORE CITY HEALTH DEPARTMENT</b><br><b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                 |  | REG. NO. <b>71 10408</b>                                                                                                                                      |  |
| M-600 71 10408<br>BIRTH NO. <b>11-18947</b>                                                                                                                                                                                                                                                                                                            |  | 2. DATE AND HOUR OF DEATH<br><b>11-7-71 5:30 PM</b>                                                                                                           |  |
| 1. NAME OF DECEASED (Type or Print)<br><b>Boy Baby Moore</b>                                                                                                                                                                                                                                                                                           |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Carroll</b> B. COUNTY <b>5800</b>                        |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Bon Secours Hospital 34</b>                                                                                                                                                  |  | C. CITY OR TOWN <b>Woodbine</b> D. INSIDE CITY LIMITS?<br><b>20000 7th</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  |
| 5. SEX <b>male</b> 6. RACE <b>white</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                  |  | 8. DATE OF BIRTH <b>11-7-71</b> 9. AGE (In years last birthday) <b>21</b> 10. Under 1 Yr. Months <b>2</b> Days <b>45</b> 11. Under 24 Hrs. Min. <b>45</b>     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                            |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                             |  |
| 13. FATHER'S NAME<br><b>John Moore</b>                                                                                                                                                                                                                                                                                                                 |  | 14. MOTHER'S MAIDEN NAME<br><b>Wanda Wright</b>                                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                               |  | 16. SOCIAL SECURITY NO.                                                                                                                                       |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                                          |  | ADDRESS                                                                                                                                                       |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>776.9 I</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br><b>Anaesthetic sensitivity CWS.</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hr. 45 min.</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                 |  |                                                                                                                                                               |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                 |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                              |  |
| 20A. AUTOPSY? (Yes or No) <b>NO</b>                                                                                                                                                                                                                                                                                                                    |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                      |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                               |  |                                                                                                                                                               |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                              |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                        |  |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11/7/71 2:45 PM</b> to <b>11/7/71 5:30 PM</b> and that (I) (we) last saw the deceased alive on <b>11/7/71</b> and that (I) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                 |  |                                                                                                                                                               |  |
| 23A. SIGNATURE<br><b>Theresa F. Toulan M.D.</b>                                                                                                                                                                                                                                                                                                        |  | 23B. DATE SIGNED<br><b>11-7-71</b>                                                                                                                            |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Theresa F. Toulan M.D.</b>                                                                                                                                                                                                                                                                                          |  | 23D. ADDRESS<br><b>715 West Hills Bldg Baltimore Md 21205</b>                                                                                                 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                               |  | 24B. DATE                                                                                                                                                     |  |
| 24C. NAME OF CEMETERY or CREMATORY                                                                                                                                                                                                                                                                                                                     |  | 24D. LOCATION (City, town, or county) (State)                                                                                                                 |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                                        |  | 25B. NAME OF REGISTRAR                                                                                                                                        |  |
| 25C. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                  |  | ADDRESS                                                                                                                                                       |  |
| <b>NOV 11 1971 Robert E. Taylor, R.D.</b>                                                                                                                                                                                                                                                                                                              |  | <b>HOSPITAL DISPOSAL</b>                                                                                                                                      |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                    |                                                                                                   |                                          |                                                                                               |                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------|
| K-420                                                                                                                                                                                                                                                                                                                                                                          |                         | 10409                                                                                                                                                       |                                    | BALTIMORE CITY HEALTH DEPARTMENT                                                                  |                                          | REG. NO. 71 10409                                                                             |                       |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |                                    | CERTIFICATE OF DEATH                                                                              |                                          |                                                                                               |                       |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Killough, Millard</i>                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                    | 2. DATE AND HOUR OF DEATH<br><i>11/8/71 1155 A.M.</i>                                             |                                          |                                                                                               |                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             |                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)             |                                          |                                                                                               |                       |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>33 Johns Hopkins Hospital</i>                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                    | A. STATE <i>Maryland</i><br>B. COUNTY <i>1607</i>                                                 |                                          |                                                                                               |                       |
|                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                    | C. CITY OR TOWN<br><i>Baltimore</i>                                                               |                                          | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                       |
|                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                    | E. STREET AND NUMBER<br><i>3031 Belmont Avenue</i>                                                |                                          |                                                                                               |                       |
| 5. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                          | 6. RACE<br><i>Negro</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>5/25/97</i> | 9. AGE (In years last birthday) <i>74</i>                                                         | If Under 1 Yr. Months: Days: Hours: Min. |                                                                                               | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Clerk</i>                                                                                                                                                                                                                                                                    |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>U.S. Gov't</i>                                                                                                      |                                    | 11. BIRTHPLACE (State or foreign country)<br><i>Tenn.</i>                                         |                                          | 12. CITIZEN OF WHAT COUNTRY?                                                                  |                       |
| 13. FATHER'S NAME<br><i>Philmer Killough</i>                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                    | 14. MOTHER'S MAIDEN NAME<br><i>America Dodge</i>                                                  |                                          |                                                                                               |                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                       |                         | 16. SOCIAL SECURITY NO.                                                                                                                                     |                                    | 17. INFORMANT ADDRESS<br><i>Mrs. Lillian Killough 3031 Belmont A</i>                              |                                          |                                                                                               |                       |
| 18. <i>162-1</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><i>Cordisginty Arrest</i><br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         |                                                                                                                                                             |                                    | CAUSE OF DEATH                                                                                    |                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |                       |
|                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                    | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Bronchogenic CA &amp; brain mets</i> |                                          |                                                                                               |                       |
|                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                    | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><i>Also Prostate CA, H/o Penile CA</i>                     |                                          |                                                                                               |                       |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                    |                                                                                                   |                                          |                                                                                               |                       |
| 19A. DATE OF OPERATION<br><i>2</i>                                                                                                                                                                                                                                                                                                                                             |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                    | 20A. AUTOPSY? (Yes or No)<br><i>Yes</i>                                                           |                                          | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><i>NO</i>             |                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                 |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                          |                                          |                                                                                               |                       |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                      |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                    | 21F. HOW DID INJURY OCCUR?                                                                        |                                          |                                                                                               |                       |
| 22. I certify that <i>1</i> (this hospital) attended the deceased from <i>10/21</i> 19 <i>71</i> to <i>11/8</i> 19 <i>71</i> that <i>1</i> (we) last saw the deceased alive on <i>11/8</i> 19 <i>71</i> and that <i>1</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>1</i> (We) (did) (did not) view the body after death.         |                         |                                                                                                                                                             |                                    |                                                                                                   |                                          |                                                                                               |                       |
| 23A. SIGNATURE<br><i>LE Rambler MD</i>                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             |                                    | 23B. DATE SIGNED<br><i>11/8/71</i>                                                                |                                          | 23C. PHYSICIAN'S NAME (Type)<br><i>LE Rambler MD</i>                                          |                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |                                    | 24B. DATE<br><i>11-13-71</i>                                                                      |                                          | 24C. NAME OF CEMETERY or CREMATORY<br><i>Mt Calvary Cemetery</i>                              |                       |
| 24D. LOCATION (City, town, or county) (State)<br><i>Anne Arundel Cty., Md.</i>                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                    | 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 11 1971</i>                                             |                                          |                                                                                               |                       |
| 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor, M.D.</i>                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                    | 25C. FUNERAL DIRECTOR ADDRESS<br><i>Wm C March 928 E. North Ave.</i>                              |                                          |                                                                                               |                       |





B-356 71 10410

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10410

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>Robert Boydner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> 11 9 71<br>6:30A. M.                                                 |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>33 Johns Hopkins Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br>11 9 71<br>6:30A. M.                                                                                                                       |  |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 7. RACE<br>Negro                                                                                                                                                                        |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | C. CITY OR TOWN<br>Baltimore                                                                                                                                                            |  |
| 9. DATE OF BIRTH<br>11/8/47                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10. AGE (In years lost birthday)<br>24                                                                                                                                                  |  |
| 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                                                                                    |  |
| 13. FATHER'S NAME<br>Nolie Boydner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 14. MOTHER'S MAIDEN NAME<br>Nannie Lee Hall                                                                                                                                             |  |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Unemployed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 16. KIND OF BUSINESS OR INDUSTRY<br>None                                                                                                                                                |  |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 18. SOCIAL SECURITY NO.<br>-                                                                                                                                                            |  |
| 19. 485 X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                             |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>Bronchopneumonia<br>DUE TO, OR AS A CONSEQUENCE OF:<br>complicating acute alcoholic intoxication<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |  |
| 20 A. DATE OF OPERATION<br>2/1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 20 B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                       |  |
| 21. AUTOPSY? (Yes or No)<br>YES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                         |  |
| 22 A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 22 B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                               |  |
| 22 C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                         |  |
| 22 D. TIME (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 22 E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                              |  |
| 22 F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                         |  |
| 23.<br>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE: [Signature] M.D.<br>EXAMINER'S NAME (Type): Werner U. Spitz, M.D.<br>DATE SIGNED: 11-10-71 |  |                                                                                                                                                                                         |  |
| 24 A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 24 B. DATE<br>11/12/71                                                                                                                                                                  |  |
| 24 C. NAME OF CEMETERY or CREMATORY<br>Mt Calvary Cemetery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 24 D. LOCATION (City, town, or county) (State)<br>Anne Arundel Co. Md.                                                                                                                  |  |
| 25 A. DATE REC'D BY HEALTH DEPT.<br>NOV 11 1971                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 25 B. NAME OF REGISTRAR<br>Robert E. Fisher, M.D.                                                                                                                                       |  |
| 25 C. FUNERAL DIRECTOR<br>William S. Spicer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | ADDRESS<br>1639 N Broadway                                                                                                                                                              |  |

1-6-72 - Letter from - Office of the Chief Medical Examiner, Werner U. Spitz, M.D.  
Deputy Chief Medical Examiner

HRS

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M 245

## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10411

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                   |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARTIN<br/>JOSEPH MC GLONE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> 11 8 1971 |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>44 Union Memorial Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>11 8 1971 6:45a                                                 |  |
| 6. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 7. RACE<br>white                                                                                                  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | C. CITY OR TOWN<br>Balto.                                                                                         |  |
| 9. DATE OF BIRTH<br>10-29-1910                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10. AGE (In years lost birthday)<br>61                                                                            |  |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                            |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Accountant                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>Margaret Walsh                                                                        |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 17. SOCIAL SECURITY NO.<br>219-05-7692                                                                            |  |
| 18. INFORMANT<br>Mrs. Joseph McGlone                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | ADDRESS<br>Same                                                                                                   |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic cardiovascular disease<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                      |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                          |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br>m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>         |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 22F. HOW DID INJURY OCCUR?                                                                                        |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED 11-8-71 |  |                                                                                                                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 24B. DATE<br>11-11-71                                                                                             |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>New Cathedral Cemetery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 24D. LOCATION (City, town, or county) (State)<br>Balto. Md.                                                       |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 11 1971                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 25B. NAME OF REGISTRAR<br>Robert E. Farber, M.D.                                                                  |  |
| 25C. FUNERAL DIRECTOR<br>H. W. Jenkins & Sons Co.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | ADDRESS<br>4905 York Road Balto., Md. 21212                                                                       |  |

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GADELYN BROWN

DATE DEPT 11

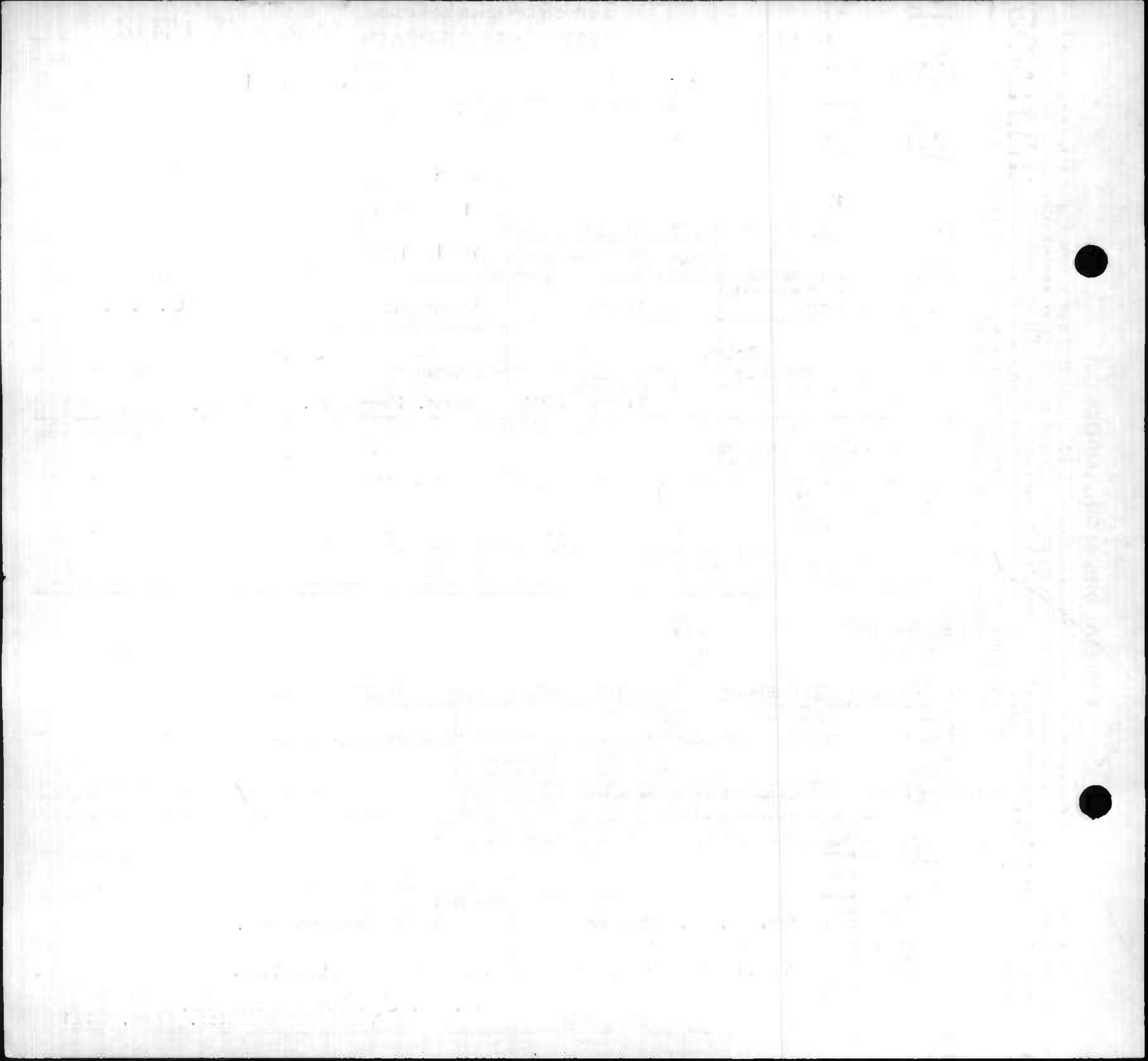
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                                                                                                                                                                                       |                                       | * REG. NO. <u>71 10412</u>                                          |                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. <u>71 10412</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                  |                                       |                                                                     |                                                        |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Grace H. Gomez</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  | 2. DATE AND HOUR OF DEATH<br><u>Nov. 9, 1971</u> <u>11 A.</u> <u>M.</u>                                                                                                                                                                                                                                               |                                       |                                                                     |                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br><u>00 917 Arran Road</u>                                                                                                                                                                                                                                                                                                         |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u> <u>5300</u><br>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>917 Arran Road</u> |                                       |                                                                     |                                                        |
| 5. SEX <u>F</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                           | 8. DATE OF BIRTH<br><u>12-19-1893</u> | 9. AGE (In years last birthday)<br><u>77</u>                        | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Homemaker</u>                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>                                                                                                                                                                                                                                                                  |                                       | 11. BIRTHPLACE (State or foreign country)<br><u>Vermont</u>         |                                                        |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 13. FATHER'S NAME<br><u>Boland</u>                                                                                                                                                                                                                                                                                    |                                       | 14. MOTHER'S MAIDEN NAME<br><u>Julia</u>                            |                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                                                                                                                                                                           |                  | 16. SOCIAL SECURITY NO.<br><u>214-18-5030</u>                                                                                                                                                                                                                                                                         |                                       | 17. INFORMANT<br><u>Mrs. Harry H. Barranger</u> ADDRESS <u>Same</u> |                                                        |
| 18. <u>41241</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><u>Antecedent Causes</u><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <u>Acute Cardiac Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <u>Secondary to advance Arteriosclerosis C.V. disease</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____                                                                                                |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |                                                        |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                      |                                       | 20A. AUTOPSY? (Yes or No) <u>No</u>                                 |                                                        |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                 |                                       |                                                                     |                                                        |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                              |                                       |                                                                     |                                                        |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                             |                                       | 21F. HOW DID INJURY OCCUR?                                          |                                                        |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> 19 <u>61</u> to <u>11/9</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11/8</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                          |                  |                                                                                                                                                                                                                                                                                                                       |                                       |                                                                     |                                                        |
| 23A. SIGNATURE<br><u>L.B. Stevens MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                                                                                                                                                                                       |                                       | 23B. DATE SIGNED<br><u>11/10/71</u>                                 |                                                        |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Dr. L. B. Stevens</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | 23D. ADDRESS<br><u>3400 Erdman Ave.</u>                                                                                                                                                                                                                                                                               |                                       |                                                                     |                                                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | 24B. DATE<br><u>11-11-71</u>                                                                                                                                                                                                                                                                                          |                                       | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Dulaney Valley Gardens</u> |                                                        |
| 24D. LOCATION (City, town, or county) (State)<br><u>Timmium. Md.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 11 1971</u>                                                                                                                                                                                                                                                                 |                                       |                                                                     |                                                        |
| 25B. NAME OF REGISTRAR<br><u>Robert E. Farber, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 25C. FUNERAL DIRECTOR<br><u>H. W. Jenkins &amp; Sons Co.</u> ADDRESS<br><u>4905 York Road Balto., Md. 21212</u>                                                                                                                                                                                                       |                                       |                                                                     |                                                        |

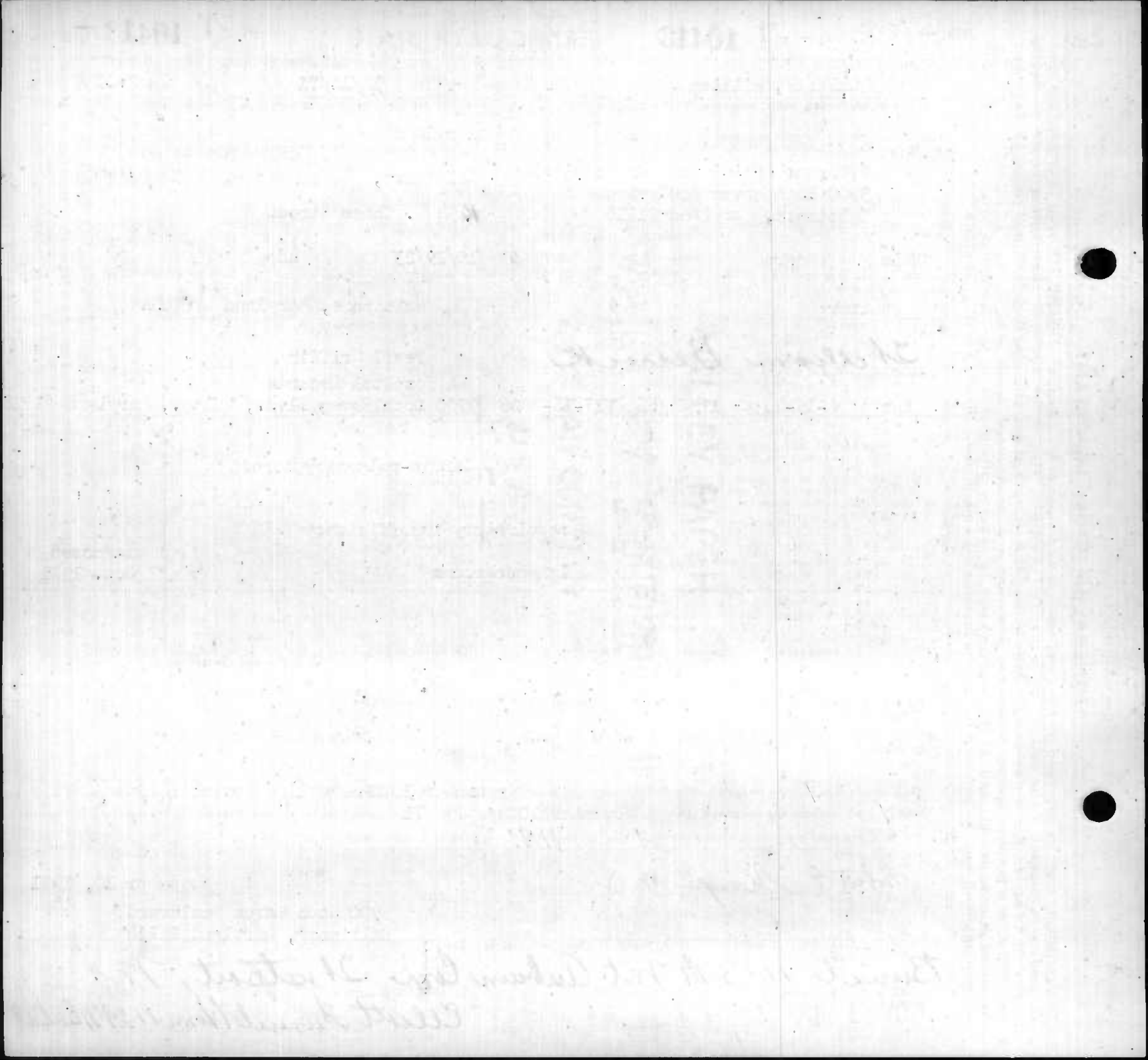




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <span style="float: right;">71 10413</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                     | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                       |                                                                         | REG. NO. <span style="float: right;">71 10413</span>                                                  |                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>GRIFFIN, William</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                     | 2. DATE AND HOUR OF DEATH<br><b>11/10/71</b>                                                                                                                                                                   |                                                                         | 2:00 A M.                                                                                             |                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                     | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>808</b>                                                                      |                                                                         |                                                                                                       |                                            |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>23 Veterans Administration Hospital<br/>3900 Loch Raven Boulevard<br/>Baltimore, Maryland 21218</b>                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                     | C. CITY OR TOWN <b>Baltimore</b>                                                                                                                                                                               |                                                                         | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |                                            |
| E. STREET AND NUMBER <b>1434 E. Chase Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                     |                                                                                                                                                                                                                |                                                                         |                                                                                                       |                                            |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6. RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/29/23</b> | 9. AGE (In years last birthday)<br><b>48</b>                                                                                                                                                                   | If Under 1 Yr. Months Days                                              |                                                                                                       | If Under 24 Hrs. Hours Min.                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Janitor</b>                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY   |                                                                                                                                                                                                                | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b> |                                                                                                       | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |
| 13. FATHER'S NAME<br><b>William Derrick</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Pearl Griffin</b>                                                                                                                                                               |                                                                         |                                                                                                       |                                            |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes 6-15-44 to 11/16/45</b>                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                     | 16. SOCIAL SECURITY NO.<br><b>217-16-1326</b>                                                                                                                                                                  |                                                                         | 17. INFORMANT ADDRESS<br><b>VA Hospital Records<br/>3900 Loch Raven Blvd., Balto., Maryland 21218</b> |                                            |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>200.1 I</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                         |                                                                                                                                                             |                                     | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Cardio-pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>respiratory insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>lymphosarcoma</b> |                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>diagnosed Oct. 1971</b>                            |                                            |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                     | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                                                                                                                                         |                                                                         | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                  |                                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                          |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                       |                                                                         |                                                                                                       |                                            |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                     | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                     |                                                                         |                                                                                                       |                                            |
| 22. I certify that (I) (this hospital) attended the deceased from <b>September 30th 1971</b> to <b>November 10th 1971</b> , that (I) (we) last saw the deceased alive on <b>November 10th 1971</b> and that in (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.                                                                                                                            |                         |                                                                                                                                                             |                                     |                                                                                                                                                                                                                |                                                                         |                                                                                                       |                                            |
| 23A. SIGNATURE<br><b>Robert E. Thompson M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                     |                                                                                                                                                                                                                |                                                                         | 23B. DATE SIGNED<br><b>November 10, 1971</b>                                                          |                                            |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Robert E. Thompson M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                     | 23D. ADDRESS<br><b>3900 Loch Raven Boulevard<br/>Baltimore, Maryland 21218</b>                                                                                                                                 |                                                                         |                                                                                                       |                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | 24B. DATE<br><b>11-13-71</b>                                                                                                                                |                                     | 24C. NAME of CEMETERY or CREMATORY<br><b>Mt Auburn Cem</b>                                                                                                                                                     |                                                                         | 24D. LOCATION (City, town, or county) (State)<br><b>Stispout, Md.</b>                                 |                                            |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 11 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Thompson M.D.</b>                                                                                                    |                                     | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Elliott Funeral Home 1129 N. Calvert</b>                                                                                                                                   |                                                                         |                                                                                                       |                                            |

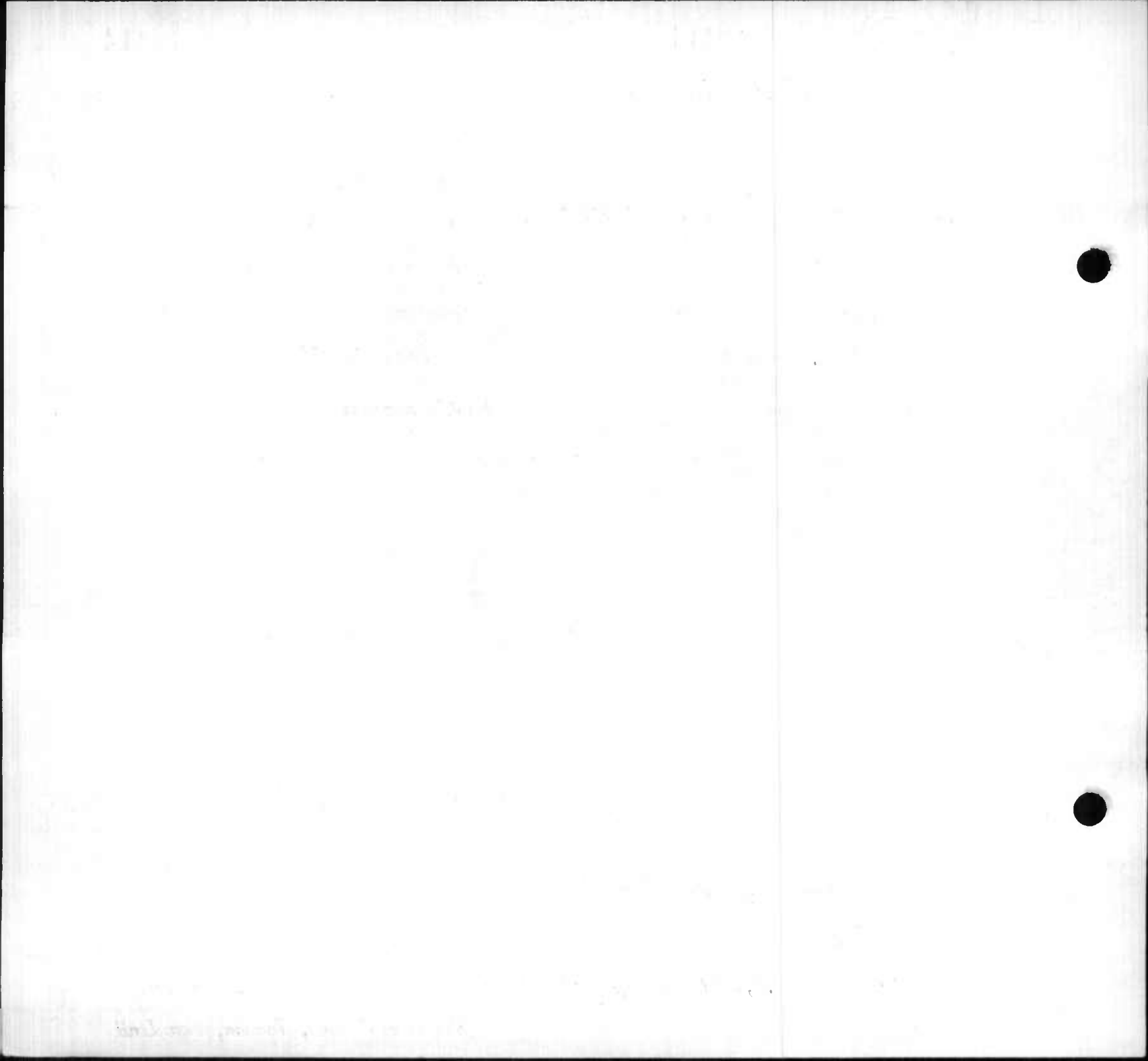




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

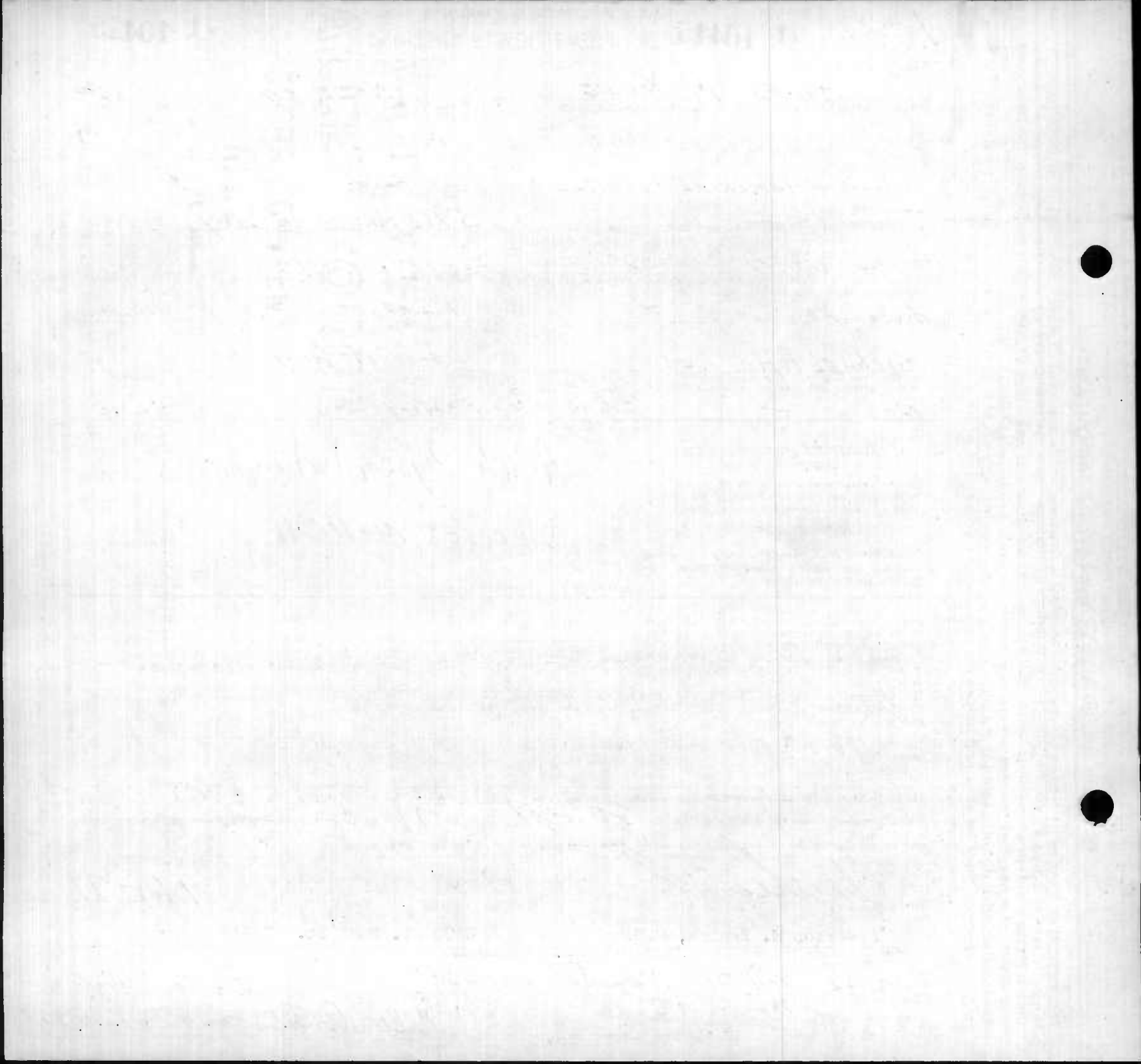
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | REG. NO. <b>71 10414</b>                                                                                                                                                                            |  |
| BIRTH NO. <b>Y-524 71 10414</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 1. NAME OF DECEASED<br>(Type or Print) <b>Patricia Yingling</b>                                                                                                                                     |  |
| 2. DATE AND HOUR OF DEATH<br><b>11-5-71 5:00 P.M.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>38 UNIVERSITY of Maryland Hospital</b>                                                                                                 |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>BALTO</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. CITY OR TOWN <b>Cockeysville</b><br>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                              |  |
| E. STREET AND NUMBER<br><b>10768 YORK Rd.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 6. SEX <b>F</b><br>7. RACE <b>W.</b><br>8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. AGE (In years last birthday) <b>27</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b><br>10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>                                 |  |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                                                                             |  |
| 13. FATHER'S NAME<br><b>Austin L. Bennett</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br><b>Marjorie Wilson</b>                                                                                                                                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>No</b><br>(If yes, give war or dates of service) <b>None</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16. SOCIAL SECURITY NO.                                                                                                                                                                             |  |
| 17. INFORMANT<br><b>Family records</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | ADDRESS                                                                                                                                                                                             |  |
| 18. <b>4-31-9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>INTRACEREBRAL Hemorrhage -</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>(A) IMMEDIATE CAUSE</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                        |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Pulmonary Abscess -</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                     |  |
| 19A. DATE OF OPERATION <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                    |  |
| 20A. AUTOPSY? (Yes or No) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                            |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                           |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                          |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>7-17</b> 19 <b>71</b> to <b>11-5</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>11-5</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                   |  |                                                                                                                                                                                                     |  |
| 23A. SIGNATURE<br><b>Jose Y. Iglesias M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 23B. DATE SIGNED                                                                                                                                                                                    |  |
| 23C. PHYSICIAN'S NAME (Type) <b>Jose Y. Iglesias M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 23D. ADDRESS<br><b>University of Maryland Hospital</b>                                                                                                                                              |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 24B. DATE <b>Nov. 9, 1971</b>                                                                                                                                                                       |  |
| 24C. NAME of CEMETERY or CREMATORY <b>Jessops Methodist Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 24D. LOCATION (City, town, or county) (State) <b>Cockeysville, Maryland</b>                                                                                                                         |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 11 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>                                                                                                                                                |  |
| 25C. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | ADDRESS                                                                                                                                                                                             |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

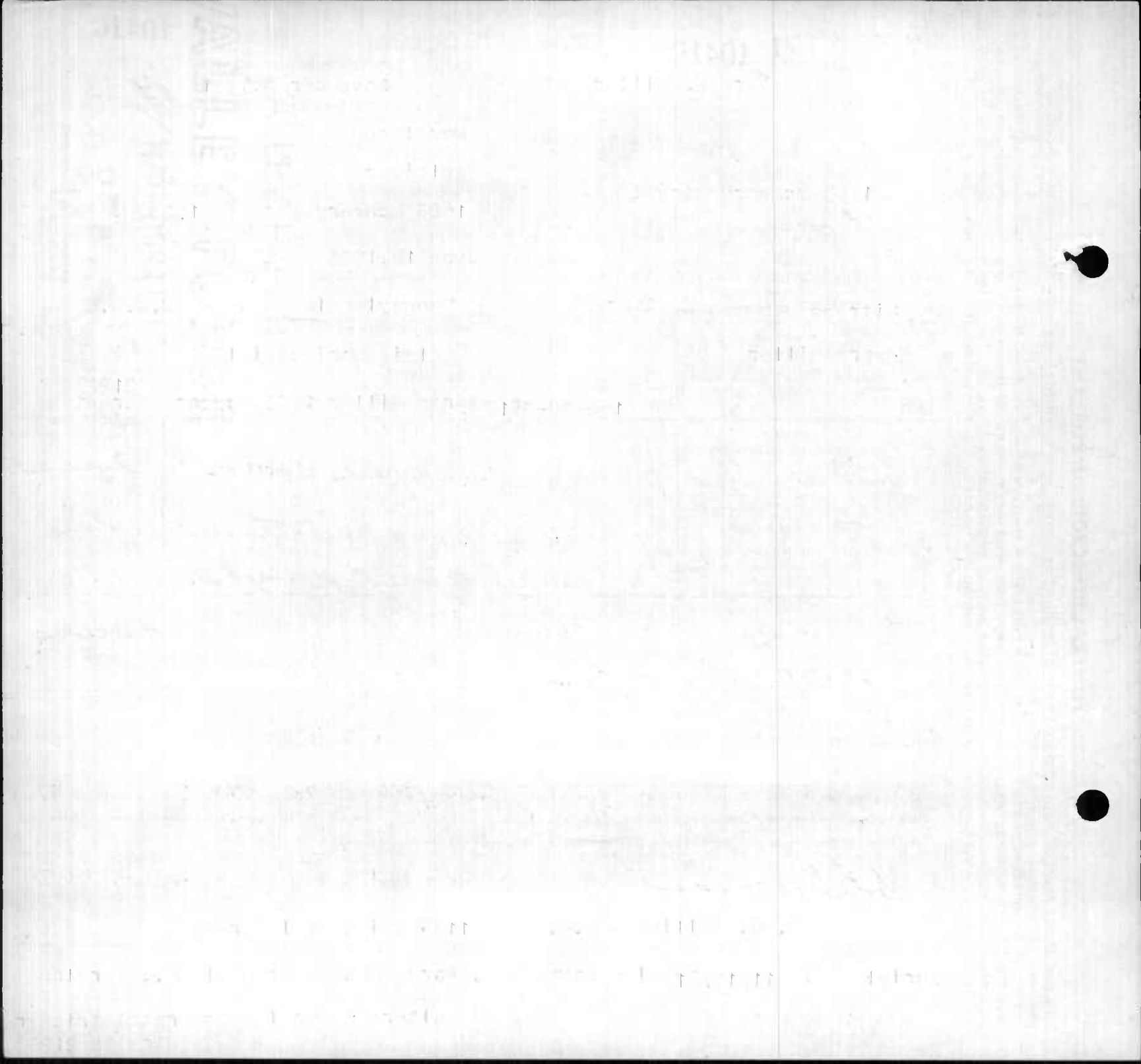
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                          |  | REG. NO. <b>71 10415</b>                                                                      |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|
| V-520 71 10415                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                          |  | CERTIFICATE OF DEATH                                                                          |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>AGNES M. YOUNG</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 2. DATE AND HOUR OF DEATH<br><b>Nov. 8, 1971</b> <b>1045</b> M.                                                                                          |  |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>2741</b>                       |  |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNION MEMORIAL HOSPITAL</b><br><b>44</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | C. CITY OR TOWN<br><b>BALTO.</b>                                                                                                                         |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>FEB. 17, 1899</b> 9. AGE (In years last birthday) <b>72</b>               |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                                                                                                            |  | 11. BIRTHPLACE (State or foreign country)<br><b>BALTO</b>                                     |  |
| 13. FATHER'S NAME<br><b>MICHAEL P. HOLMES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 14. MOTHER'S MAIDEN NAME<br><b>DELIA MCGARY</b>                                                                                                          |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                 |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 16. SOCIAL SECURITY NO. <b>B 216-10-0870</b>                                                                                                             |  | 17. INFORMANT <b>FAMILY</b> ADDRESS <b>SAME</b>                                               |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                               |  |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><b>2501 I</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p><b>ACUTE MYOCARDIAL INFARCTION</b></p> <p><b>DIABETES MELLITUS</b></p> </div> </div> |  |                                                                                                                                                          |  |                                                                                               |  |
| <p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                          |  |                                                                                               |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  | 20A. AUTOPSY? (Yes or No)                                                                     |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?                                                                    |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>15 June 1965</b> to <b>8 Nov 1971</b> , that (I) (we) last saw the deceased alive on <b>10 Sept 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                |  |                                                                                                                                                          |  |                                                                                               |  |
| 23A. SIGNATURE<br><b>Anderson M. Renick</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                          |  | 23B. DATE SIGNED<br><b>9 Nov 71</b>                                                           |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Anderson M. Renick, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                          |  | 23D. ADDRESS<br><b>3100 St. Paul St. 21218</b>                                                |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 24B. DATE<br><b>8-11-71</b>                                                                                                                              |  | 24C. NAME of CEMETERY or CREMATION<br><b>NEW CATHEDRAL</b>                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 11 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>                                                                                                  |  | 25C. FUNERAL DIRECTOR<br><b>J. Walter Conklin</b> ADDRESS <b>5444 BELAIR Rd.</b>              |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

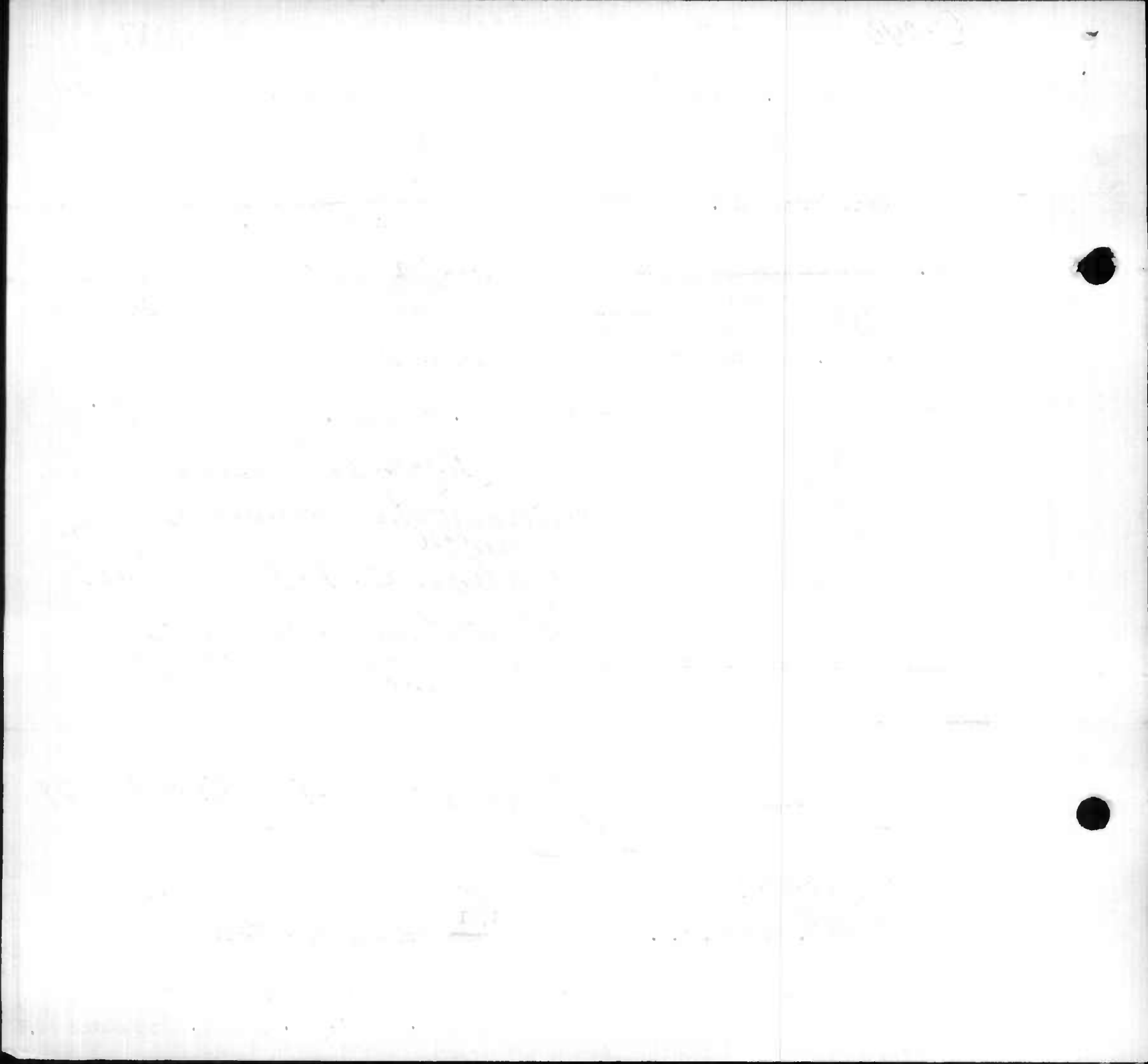
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                             |                                                    | REG. NO. <u>71 10416</u>                                                                      |                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------|
| BIRTH NO. <u>M-460 71 10416</u>                                                                                                                                                                                                                                                                                                                                                       |                     | CERTIFICATE OF DEATH                                                                                                                                        |                                                    |                                                                                               |                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Vera E. Miller</u>                                                                                                                                                                                                                                                                                                                          |                     | 2. DATE AND HOUR OF DEATH<br><u>November 8, 1971</u> <u>9:10</u> M.                                                                                         |                                                    |                                                                                               |                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>00 1603 McHenry Street</u>                                                                                                                                                                              |                     | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>1903</u>                  |                                                    |                                                                                               |                                           |
|                                                                                                                                                                                                                                                                                                                                                                                       |                     | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                         |                                                    | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                           |
|                                                                                                                                                                                                                                                                                                                                                                                       |                     | E. STREET AND NUMBER<br><u>1603 McHenry Street 21223</u>                                                                                                    |                                                    |                                                                                               |                                           |
| 5. SEX<br><u>F</u>                                                                                                                                                                                                                                                                                                                                                                    | 6. RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>June 16, 1925</u> <u>46</u> | 9. AGE (In years last birthday)                                                               | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Waitress</u>                                                                                                                                                                                                                                                                        |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Restaurant</u>                                                                                                      |                                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Pennsylvania</u>                              |                                           |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                                                                                                                                                                                                                         |                     | 13. FATHER'S NAME<br><u>Edward Miller</u>                                                                                                                   |                                                    | 14. MOTHER'S MAIDEN NAME<br><u>Elsie Critchfield</u>                                          |                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                                                 |                     | 16. SOCIAL SECURITY NO.<br><u>162-20-2519</u>                                                                                                               |                                                    | 17. INFORMANT<br><u>Karen Miller 1603 McHenry Street</u>                                      |                                           |
| 18. <u>15411</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><u>Carcinoma Rectum</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(A) IMMEDIATE CAUSE<br>(B) <u>Widespread metastases</u><br>(C) <u>intraabdominal, perineal etc</u> |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 years</u><br><u>1 year</u><br><u>4 weeks</u>                                                           |                                                    |                                                                                               |                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>Uremia</u>                                                                                                                                                                                                                               |                     |                                                                                                                                                             |                                                    |                                                                                               |                                           |
| 19A. DATE OF OPERATION<br><u>1-29-70</u>                                                                                                                                                                                                                                                                                                                                              |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Ca of Rectum</u>                                                                                     |                                                    | 20A. AUTOPSY? (Yes or No)<br><u>No</u>                                                        |                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                     |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><input type="checkbox"/>                                        |                                                    | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                   |                                           |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                          |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                    | 21F. HOW DID INJURY OCCUR?                                                                    |                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan 26 1970</u> to <u>Nov 8 1971</u> , that (I) <del>(was)</del> last saw the deceased alive on <u>Nov 8 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we) (did)</del> (did not) view the body after death.                            |                     |                                                                                                                                                             |                                                    |                                                                                               |                                           |
| 23A. SIGNATURE<br><u>S. G. Sullivan</u><br>DEGREE                                                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                             |                                                    | 23B. DATE SIGNED<br><u>Nov 9 1971</u>                                                         |                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><u>S. G. Sullivan, M.D.</u><br>DEGREE                                                                                                                                                                                                                                                                                                                 |                     |                                                                                                                                                             |                                                    | 23D. ADDRESS<br><u>1129 Saint Paul Street</u>                                                 |                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                             |                     | 24B. DATE<br><u>11/12/71</u>                                                                                                                                |                                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Glen Haven Mem. Park</u>                             |                                           |
| 24D. LOCATION (City, town, or county) (State)<br><u>Anne Arundel Co., Maryland</u>                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                             |                                                    |                                                                                               |                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 11 1971</u>                                                                                                                                                                                                                                                                                                                                 |                     | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, M.D.</u>                                                                                                     |                                                    | 25C. FUNERAL DIRECTOR<br><u>Walters Funeral Home Pratt &amp; Stricker</u>                     |                                           |
|                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             |                                                    | ADDRESS<br><u>Streets 21223</u>                                                               |                                           |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                   |                     |                                                                                                                                                                                                                                                                                 |                                     | REG. NO. <u>71 10417</u>                                                                      |                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------|
| BIRTH NO. <u>C-240 71 10417</u>                                                                                                                                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                                                                                                                                                 |                                     |                                                                                               |                                                  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Viola M. Cecil</u>                                                                                                                                                                                                                                                                                                                                                                               |                     | 2. DATE AND HOUR OF DEATH<br><u>November 9, 1971</u> <u>6 AM</u> M.                                                                                                                                                                                                             |                                     |                                                                                               |                                                  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                     |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>2758</u>                                                                                                                                         |                                     |                                                                                               |                                                  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>6201 Loch Raven Blvd.</u>                                                                                                                                                                                                                                                                                                  |                     | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                                                                                                                                             |                                     | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     | E. STREET AND NUMBER<br><u>6201 Loch Raven Blvd.</u>                                                                                                                                                                                                                            |                                     |                                                                                               |                                                  |
| 5. SEX<br><u>F.</u>                                                                                                                                                                                                                                                                                                                                                                                                                        | 6. RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                     | 8. DATE OF BIRTH<br><u>7/11/'89</u> | 9. AGE (In years last birthday)<br><u>82</u>                                                  | If Under 1 Yr. Months Days If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                                                                                                                                                                                                            |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br>-----                                                                                                                                                                                                                                      |                                     | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                  |                                                  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                                                                                                                                                                                                                                                                                                                                 |                     | 13. FATHER'S NAME<br><u>Robert G. Simmons</u>                                                                                                                                                                                                                                   |                                     | 14. MOTHER'S MAIDEN NAME<br><u>Ida Martin</u>                                                 |                                                  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                                                                                                      |                     | 16. SOCIAL SECURITY NO.<br><u>274-03-75890</u>                                                                                                                                                                                                                                  |                                     | 17. INFORMANT<br><u>Mr. Malcolm E. Wagner</u>                                                 |                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     | ADDRESS<br><u>6201 Loch Raven Blvd.</u>                                                                                                                                                                                                                                         |                                     |                                                                                               |                                                  |
| 18. <u>410.01</u> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                           |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                    |                                     |                                                                                               |                                                  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                           |                     | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Myocardial Infarction</u> <u>1 day.</u><br><u>Arteriosclerotic Cardiovascular disease</u> <u>years.</u><br>(B) <u>disease</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <u>Hypertensive C. I. D.</u> <u>years.</u> |                                     |                                                                                               |                                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>Cholecystectomy about 10 days ago</u>                                                                                                                                                                                                                                                         |                     |                                                                                                                                                                                                                                                                                 |                                     |                                                                                               |                                                  |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                                                                                                         |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                |                                     | 20A. AUTOPSY? (Yes or No)<br><u>no</u>                                                        |                                                  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                                                                                                                                                 |                                     |                                                                                               |                                                  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                      |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                                                                                                                                         |                                     | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                   |                                                  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                               |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                       |                                     | 21F. HOW DID INJURY OCCUR?                                                                    |                                                  |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>August</u> 19 <u>68</u> to <u>Nov. 9</u> 19 <u>71</u> that (I) ( <del>was</del> ) last saw the deceased alive on <u>Nov. 8</u> 19 <u>71</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) ( <del>do not</del> ) view the body after death. |                     |                                                                                                                                                                                                                                                                                 |                                     |                                                                                               |                                                  |
| 23A. SIGNATURE<br><u>C. Aranaga</u>                                                                                                                                                                                                                                                                                                                                                                                                        |                     | 23B. DATE SIGNED<br><u>Nov. 10-71</u>                                                                                                                                                                                                                                           |                                     |                                                                                               |                                                  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>CARLOS E. ARANAGA, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                             |                     | 23D. ADDRESS<br><u>1001 Meridene Drive 21239</u>                                                                                                                                                                                                                                |                                     |                                                                                               |                                                  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                  |                     | 24B. DATE<br><u>11/11/'71</u>                                                                                                                                                                                                                                                   |                                     | 24C. NAME OF CEMETERY or CREMATORY<br><u>Western Cemetery</u>                                 |                                                  |
| 24D. LOCATION<br><u>Baltimore, Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                                                                                                                                                 |                                     |                                                                                               |                                                  |
| 25A. DATE RECEIVED BY HEALTH DEPT.<br><u>NOV 11 1971</u>                                                                                                                                                                                                                                                                                                                                                                                   |                     | 25B. NAME OF REGISTRAR<br><u>James E. Hickey, R.D.</u>                                                                                                                                                                                                                          |                                     | 25C. FUNERAL DIRECTOR<br><u>John A. Moran, Inc.</u>                                           |                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                                                                                                                                                 |                                     | ADDRESS<br><u>3000 E. Baltimore St.</u>                                                       |                                                  |







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                       |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                            |                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| D-242 <span style="margin-left: 50px;">71 10418</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                       | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                        | REG. NO. <span style="margin-left: 20px;">71 10418</span>                                                                                                  |                                                           |
| 1. NAME OF DECEASED<br>Type or Print <span style="margin-left: 20px;">Clarice B. Douglas</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                       |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><span style="margin-left: 20px;">11-8-71</span> <span style="margin-left: 20px;">11:30 A.M.</span>                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                            |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION <span style="margin-left: 20px;">(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</span><br><span style="margin-left: 20px;">37 Mercy Hospital</span>                                                                                                                                                                                                                                                                                    |                                                       |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <span style="margin-left: 20px;">Md</span> B. COUNTY <span style="margin-left: 20px;">AA Co</span><br>C. CITY OR TOWN <span style="margin-left: 20px;">Pasadena</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <span style="margin-left: 20px;">8141 Orchard Pt Rd</span> |                                                                                                                                                            |                                                           |
| 5. SEX <span style="margin-left: 20px;">F</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. RACE <span style="margin-left: 20px;">White</span> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <span style="margin-left: 20px;">5-7-06</span>                                                                                                                                                                                                                                                                                                                                                                                        | 9. AGE (In years last birthday) <span style="margin-left: 20px;">65</span>                                                                                 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="margin-left: 20px;">Recpt</span>                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                       | 10B. KIND OF BUSINESS OR INDUSTRY <span style="margin-left: 20px;">State Office</span>                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 11. BIRTHPLACE (State or foreign country) <span style="margin-left: 20px;">Md</span>                                                                       |                                                           |
| 12. CITIZEN OF WHAT COUNTRY? <span style="margin-left: 20px;">USA</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                       |                                                                                                                                                             | 13. FATHER'S NAME <span style="margin-left: 20px;">Clarence E Brickley Sr</span>                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                            |                                                           |
| 14. MOTHER'S MAIDEN NAME <span style="margin-left: 20px;">Mary E Wilson</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                       |                                                                                                                                                             | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="margin-left: 20px;">No</span>                                                                                                                                                                                                                                                                                                    |                                                                                                                                                            |                                                           |
| 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                       |                                                                                                                                                             | 17. INFORMANT <span style="margin-left: 20px;">Clarence E Brickley Jr</span> ADDRESS <span style="margin-left: 20px;">Same</span>                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                            |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                        |                                                       |                                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><span style="margin-left: 20px;">Pulmonary edema and</span><br>(B) <span style="margin-left: 20px;">Bronchopneumonia</span><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <span style="margin-left: 20px;"></span>                                                                                                                                                             |                                                                                                                                                            |                                                           |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><span style="margin-left: 20px;">3 days</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                       |                                                                                                                                                             | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><span style="margin-left: 20px;">Astrocytoma 81 III</span>                                                                                                                                                                                                                                                         |                                                                                                                                                            |                                                           |
| 19A. DATE OF OPERATION <span style="margin-left: 20px;">11/5/71</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                       | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 20A. AUTOPSY? (Yes or No) <span style="margin-left: 20px;">YES</span>                                                                                      |                                                           |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="margin-left: 20px;">YES</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                       | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                            |                                                           |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                            |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                       | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 21F. HOW DID INJURY OCCUR?                                                                                                                                 |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="margin-left: 20px;">10/21</span> 19 <span style="margin-left: 20px;">71</span> to <span style="margin-left: 20px;">11/8</span> 19 <span style="margin-left: 20px;">71</span> that (I) (we) last saw the deceased alive on <span style="margin-left: 20px;">11/8/71</span> 19 <span style="margin-left: 20px;">71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                                       |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                            |                                                           |
| 23A. SIGNATURE <span style="margin-left: 20px;">Charles J. Lancelotti MD</span> DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                       |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 23B. DATE SIGNED <span style="margin-left: 20px;">11/8/71</span>                                                                                           |                                                           |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                       |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 23D. ADDRESS                                                                                                                                               |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <span style="margin-left: 20px;">Burial</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                       | 24B. DATE <span style="margin-left: 20px;">11/12/71</span>                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 24C. NAME OF CEMETERY OR CREMATORY <span style="margin-left: 20px;">Moreland Mem Pk</span>                                                                 |                                                           |
| 24D. LOCATION (City, town, or county) <span style="margin-left: 20px;">Balto Co Md</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                       | 24E. STATE (State) <span style="margin-left: 20px;">Md</span>                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                            |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT. <span style="margin-left: 20px;">NOV 11 1971</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                       | 25B. NAME OF REGISTRAR <span style="margin-left: 20px;">Robert E. Fisher, R.D.</span>                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 25C. FUNERAL DIRECTOR <span style="margin-left: 20px;">Mc Gully F. H. M. F. Tuck</span> ADDRESS <span style="margin-left: 20px;">Neck Road Pasadena</span> |                                                           |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                                                                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| B-656 71 10419                                                                                                                                                                                                                                                                                                                              |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |  | REG. NO. 71 10419                                                                                                                                                         |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>BRIMMER, HELEN MA.</b>                                                                                            |  | 2. DATE AND HOUR OF DEATH<br><b>NOV. 8. 71. 9:45 P.M.</b>                                                                                                                 |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>CERTIFICATE AMENDED</b>                                                                                                                                                                                                                                                        |  | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY <b>2505</b>                       |  | 5. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                                       |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>1 1-18-71</b><br><b>SOUTH BALTIMORE GEN. HOSP.</b>                                                                                                                                                                                                                                               |  | 6. STREET AND NUMBER<br><b>4026 Pennington Ave.</b>                                                                                                         |  | 7. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                             |  |
| 8. SEX <b>Female</b> RACE <b>WHITE</b>                                                                                                                                                                                                                                                                                                      |  | 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 10. DATE OF BIRTH <b>11-2-09</b> AGE <b>71</b> (In years last birthday)                                                                                                   |  |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SALES LADY</b>                                                                                                                                                                                                                             |  | 12. KIND OF BUSINESS OR INDUSTRY                                                                                                                            |  | 13. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                                                                                              |  |
| 14. FATHER'S NAME<br><b>CHARLES BRADLEY</b>                                                                                                                                                                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME<br><b>CARRIE?</b>                                                                                                                  |  | 16. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                                           |  |
| 17. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                    |  | 18. SOCIAL SECURITY NO.<br><b>218-12-0714-A</b>                                                                                                             |  | 19. INFORMANT ADDRESS                                                                                                                                                     |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>430X1-2501</b>                                                                                                                                                                                                                                                                     |  | CAUSE OF DEATH<br><b>Acute Myocardial Infarction</b><br><b>or</b><br><b>Pulmonary Embolism</b>                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                              |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF                                                                                                          |  | (B) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                        |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                              |  | (C)                                                                                                                                                         |  | II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Diabetes mellitus ASCVD.</b> |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                      |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                                 |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                       |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)                                                                                                   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |  | 21F. HOW DID INJURY OCCUR                                                                                                                                                 |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9-29-71</b> 19 to <b>NOV. 8. 71.</b> 19 that (I) (we) last saw the deceased alive on <b>6:45pm, NOV. 8. 1971</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                                             |  |                                                                                                                                                                           |  |
| 23A. SIGNATURE<br><b>Larry Chen</b>                                                                                                                                                                                                                                                                                                         |  | 23B. DATE SIGNED<br><b>NOV. 8-71.</b>                                                                                                                       |  | 23C. PHYSICIAN'S NAME (Type)<br><b>TAW YU CHENG M.D.</b>                                                                                                                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                   |  | 24B. DATE<br><b>11-11-71</b>                                                                                                                                |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>GLEN HAVEN</b>                                                                                                                   |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Ridgely Hwy Glen Burnie MD</b>                                                                                                                                                                                                                                                          |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 11 1971</b>                                                                                                       |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>                                                                                                                   |  |
| 25C. FUNERAL DIRECTOR ADDRESS<br><b>HAHN FUNERAL Home</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                                                                           |  |

Letter from South Balto. Gen'l Hosp.  
11-18-71 M.H.

RECEIVED  
11-11-71  
J. H. A. S.

| H-400 71 10420                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                 |                                                                                                                                    | 71 10420                                                                                                                    |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |                                                                                                                                    | REG. NO.                                                                                                                    |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |                                                                                                                                    |                                                                                                                             |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>WHITRIDGE E. HOWELL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.                    |                                                                                                                             |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 568 Pressman St.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>11 7 1971 3:45p</b> M.                                                        |                                                                                                                             |  |
| 6. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>1403</b> |                                                                                                                             |  |
| 7. RACE<br><b>negro</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                    | C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>Oct 21-16</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10. AGE (In years last birthday)<br><b>55</b>                                                                                                    |                                                                                                                                    | E. STREET AND NUMBER<br><b>586 Pressman St.</b>                                                                             |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                     |                                                                                                                                    | 13. FATHER'S NAME<br><b>Dennis Howell</b>                                                                                   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                |                                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br><b>Max Cella Harris</b>                                                                         |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>War II</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 17. SOCIAL SECURITY NO.<br><b>213-084923</b>                                                                                                     |                                                                                                                                    | 18. INFORMANT ADDRESS<br><b>Ruth Fawcett</b>                                                                                |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary tuberculosis</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                  |  |                                                                                                                                                  |                                                                                                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |                                                                                                                                    | 21. AUTOPSY? (Yes or No)<br><b>no</b>                                                                                       |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                         |                                                                                                                                    | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                    |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                        |                                                                                                                                    | 22F. HOW DID INJURY OCCUR?                                                                                                  |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> DATE SIGNED <b>11-8-71</b><br>EXAMINER'S NAME (Type) |  |                                                                                                                                                  |                                                                                                                                    |                                                                                                                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 24B. DATE<br><b>11-12-71</b>                                                                                                                     |                                                                                                                                    | 24C. NAME of CEMETERY or CREMATORY<br><b>Gottsburg National Cemetery</b>                                                    |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Penn.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 11 1971</b>                                                                                            |                                                                                                                                    | 25B. NAME OF REGISTRAR<br><b>Robert J. Fisher, Jr.</b>                                                                      |  |
| 25C. FUNERAL DIRECTOR<br><b>Rayner Sanders</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 25D. ADDRESS<br><b>2176 Preston</b>                                                                                                              |                                                                                                                                    |                                                                                                                             |  |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                                                                                                                                                                                                                        |                                     | REG. NO. <u>71 10421</u>                                                    |                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------|
| A-450 71 10421<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                                                                                                                                                                                                        |                                     |                                                                             |                                                             |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Allen James</u>                                                                                                                                                                                                                                                                                                     |                  | 2. DATE AND HOUR OF DEATH<br><u>Nov 6, 1971</u> <u>9:20 a.m.</u>                                                                                                                                                                                                                                                                       |                                     |                                                                             |                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br><u>UNION MEMORIAL HOSPITAL</u>                                                                                                                                                                                                                                                                  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u><br>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>5011 Plymouth Road Bldg. 14</u> |                                     |                                                                             |                                                             |
| 5. SEX <u>M</u>                                                                                                                                                                                                                                                                                                                                               | 6. RACE <u>B</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                       | 8. DATE OF BIRTH<br><u>09-26-11</u> | 9. AGE (In years last birthday)<br><u>60</u>                                | 10. UNDER 1 Yr. Months Days<br>11. UNDER 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>                                                                                                                                                                                                                                                 |                  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                      |                                     | 11. BIRTHPLACE (State or foreign country)<br><u>VIRGINIA</u>                |                                                             |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>AMERICAN</u>                                                                                                                                                                                                                                                                                                               |                  | 13. FATHER'S NAME<br><u>BOOKER ALLEN</u>                                                                                                                                                                                                                                                                                               |                                     | 14. MOTHER'S MAIDEN NAME<br><u>UNIK nowni</u>                               |                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                      |                  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                |                                     | 17. INFORMANT<br><u>CHART</u>                                               |                                                             |
| 18. <u>410.9 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.      |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>cardiac arrest</u><br>(B) <u>cause MI</u><br>(C) _____                                                                                                                                                                                                     |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u>              |                                                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                        |                  |                                                                                                                                                                                                                                                                                                                                        |                                     |                                                                             |                                                             |
| 19A. DATE OF OPERATION<br><u>2</u>                                                                                                                                                                                                                                                                                                                            |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                       |                                     | 20A. AUTOPSY? (Yes or No)<br><u>YES</u>                                     |                                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                         |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                               |                                     | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |                                                             |
| 21D. TIME OF INJURY (APPROX.)<br>1 Month ( ) Day ( ) Year ( ) Hour ( )                                                                                                                                                                                                                                                                                        |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                              |                                     | 21F. HOW DID INJURY OCCUR?                                                  |                                                             |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-20-71</u> 19 <u>71</u> to <u>11-6-71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Nov 6</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |                                                                                                                                                                                                                                                                                                                                        |                                     |                                                                             |                                                             |
| 23A. SIGNATURE<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                          |                  | 23B. DATE SIGNED                                                                                                                                                                                                                                                                                                                       |                                     | 23C. PHYSICIAN'S NAME (Type)<br><u>John Beaton</u>                          |                                                             |
| 23D. ADDRESS<br><u>UNION MEMORIAL HOSP</u>                                                                                                                                                                                                                                                                                                                    |                  | 23E. ADDRESS<br><u>UNION MEMORIAL HOSP</u>                                                                                                                                                                                                                                                                                             |                                     | 23F. ADDRESS<br><u>UNION MEMORIAL HOSP</u>                                  |                                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Shipped</u>                                                                                                                                                                                                                                                                                                    |                  | 24B. DATE<br><u>Nov 10-71</u>                                                                                                                                                                                                                                                                                                          |                                     | 24C. NAME OF CEMETERY or CREMATORY<br><u>Buckingham to Virginia</u>         |                                                             |
| 24D. LOCATION (City, town, or county) (State)<br><u>Richmond VA</u>                                                                                                                                                                                                                                                                                           |                  | 24E. LOCATION (City, town, or county) (State)<br><u>Richmond VA</u>                                                                                                                                                                                                                                                                    |                                     | 24F. LOCATION (City, town, or county) (State)<br><u>Richmond VA</u>         |                                                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 11 1971</u>                                                                                                                                                                                                                                                                                                         |                  | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, M.D.</u>                                                                                                                                                                                                                                                                                |                                     | 25C. FUNERAL DIRECTOR<br><u>Rayner Sanders</u>                              |                                                             |
| 25D. ADDRESS<br><u>2176 Preston St</u>                                                                                                                                                                                                                                                                                                                        |                  | 25E. ADDRESS<br><u>2176 Preston St</u>                                                                                                                                                                                                                                                                                                 |                                     | 25F. ADDRESS<br><u>2176 Preston St</u>                                      |                                                             |

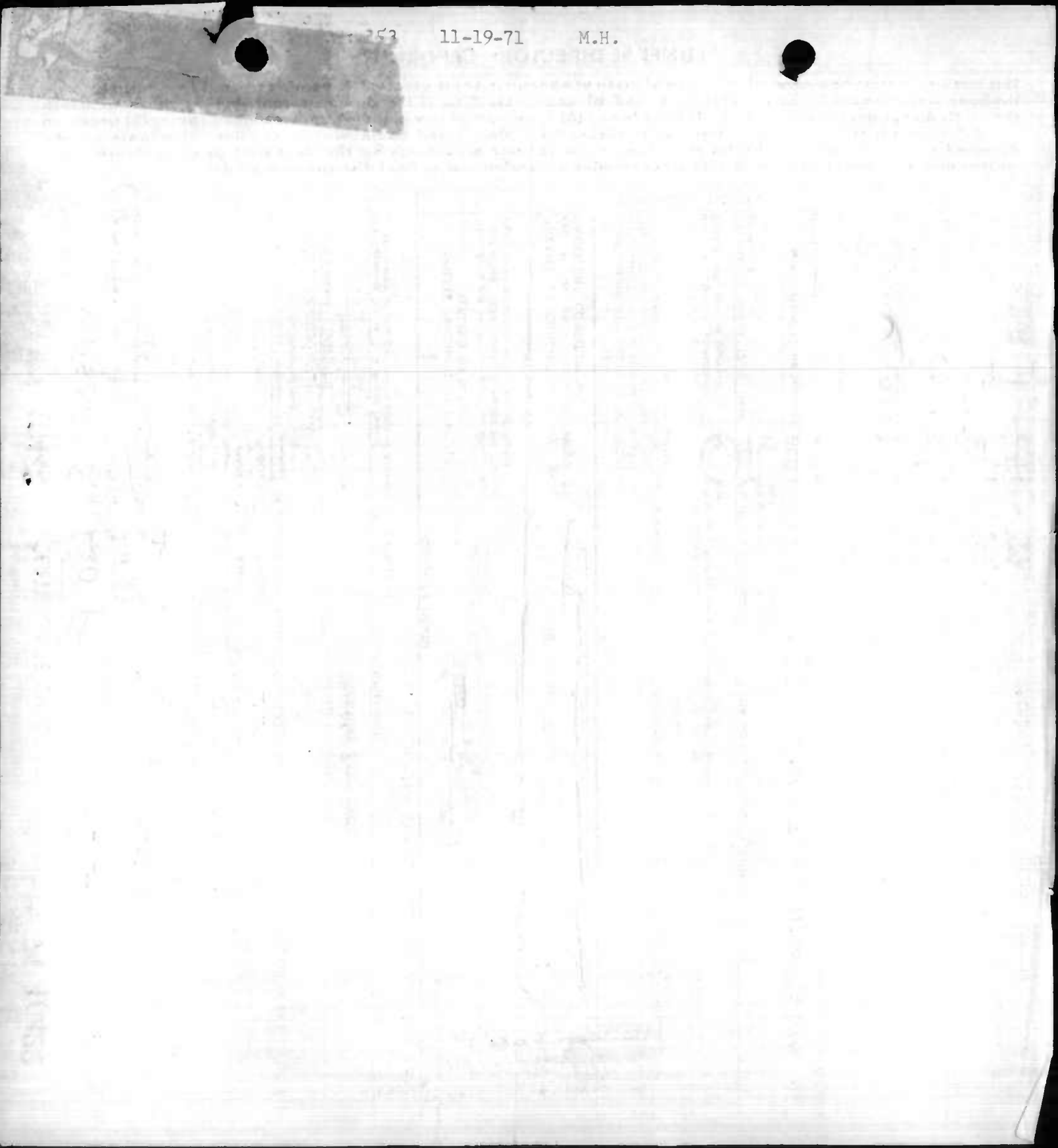




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

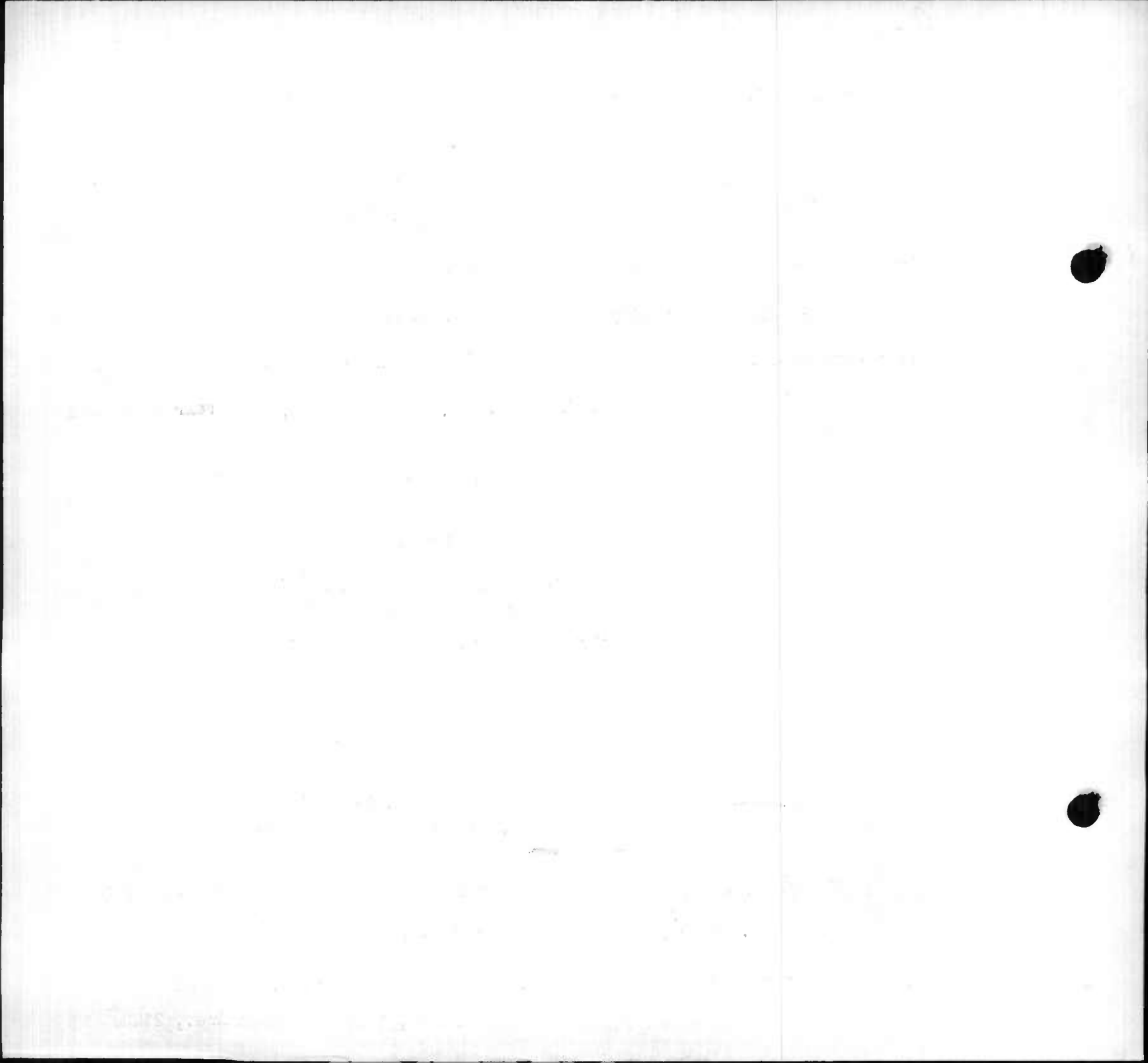
| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | REG. NO. 71 10422                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|
| BIRTH NO. 71 10422                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  |                                                                          |
| 1. NAME OF DECEASED<br>(Type or Print) <b>GREEN EDWARD F</b>                                                                                                                                                                                                                                                                                          |  | 2. DATE AND HOUR OF DEATH<br><b>11-10-71 6:40 PM</b>                                                                                         |  |                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>CERTIFICATE AMENDED</b>                                                                                                                                                                                                                                                                  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> |  |                                                                          |
| 5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                   |  | C. CITY OR TOWN <b>Woodlawn</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |                                                                          |
| 8. DATE OF BIRTH <b>9-4-24</b> 9. AGE (in years last birthday) <b>47</b>                                                                                                                                                                                                                                                                              |  | E. STREET AND NUMBER <b>7018 Glenspring Road</b>                                                                                             |  |                                                                          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Social Security Clerk</b>                                                                                                                                                                                                                           |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>                                                                                    |  |                                                                          |
| 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                     |  | 12. CITIZEN OF WHAT COUNTRY <b>USA</b>                                                                                                       |  |                                                                          |
| 13. FATHER'S NAME <b>Edward Frederick E. Green</b>                                                                                                                                                                                                                                                                                                    |  | 14. MOTHER'S MAIDEN NAME <b>Nettie Krespach</b>                                                                                              |  |                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                              |  | 16. SOCIAL SECURITY NO.                                                                                                                      |  |                                                                          |
| 17. INFORMANT <b>Mrs. Catherine Green</b>                                                                                                                                                                                                                                                                                                             |  | ADDRESS <b>21207 7018 Glenspring Road</b>                                                                                                    |  |                                                                          |
| 18. <b>470.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Probable MI</b><br><b>MYOCARDIAL INFARCTION</b><br><b>SUBCUTANEOUS HEMORRHAGE</b>                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>11/10/71</b>                                                                              |  |                                                                          |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Probable Drug Rx Contraindication</b>                                                                                                                                                                            |  |                                                                                                                                              |  |                                                                          |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                |  |                                                                                                                                              |  |                                                                          |
| 19A. DATE OF OPERATION <b>11-10-71</b>                                                                                                                                                                                                                                                                                                                |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                             |  | 20A. AUTOPSY? (Yes or No) <b>Yes</b>                                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                 |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                     |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                             |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                       |  | 21F. HOW DID INJURY OCCUR?                                               |
| 22. I certify that (1) (this hospital) attended the deceased from <b>11/9 2:30 PM 1971</b> to <b>11/10 6:40 AM 1971</b> that (1) (we) last saw the deceased alive on <b>11/10/71 6:30 AM</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                              |  |                                                                          |
| 23A. SIGNATURE <b>Shaw K. W. Nittler</b>                                                                                                                                                                                                                                                                                                              |  | 23B. DATE SIGNED                                                                                                                             |  | 23C. PHYSICIAN'S NAME (Type) <b>SHAW K. W. NITTLER</b>                   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                |  | 24B. DATE <b>11-15-71</b>                                                                                                                    |  | 24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>                  |
| 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                                              |  | 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 12 1971</b> 25B. NAME OF REGISTRAR <b>Robert E. Vicker, M.D.</b>                                      |  |                                                                          |
| 25C. FUNERAL DIRECTOR <b>Witzke</b>                                                                                                                                                                                                                                                                                                                   |  | ADDRESS <b>1630 Edmondson Avenue 21228</b>                                                                                                   |  |                                                                          |



# FUNERAL DIRECTOR: IMPORTANT

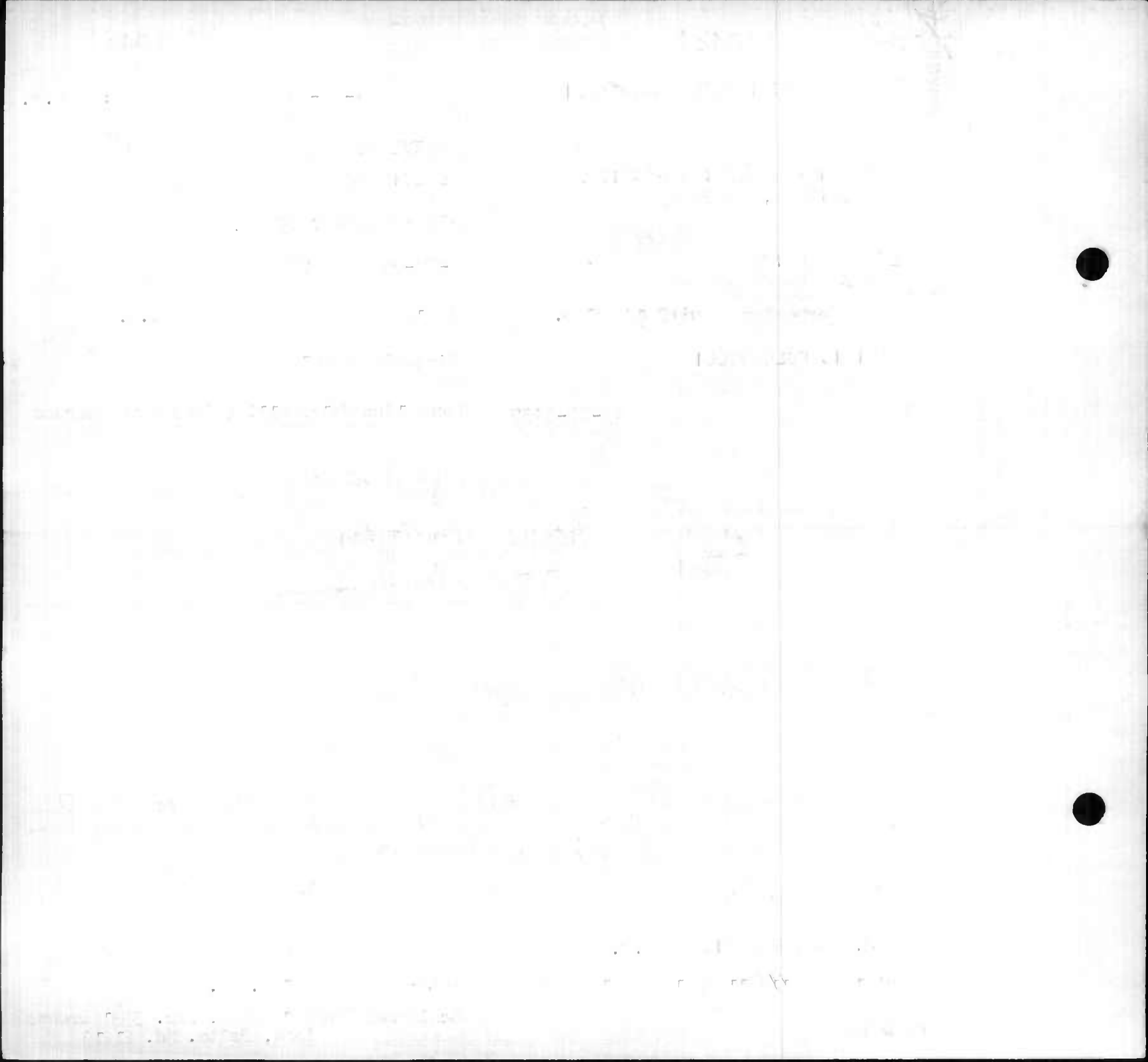
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <div style="display: flex; justify-content: space-between;"> <span>B-220 71 10423</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>                                                                                                                    |  | REG. NO. 71 10423                                                                                                                                                                                   |  |
| BIRTH NO. <span style="float: right;">1</span>                                                                                                                                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br><div style="display: flex; justify-content: space-between;"> <span>11/11/71</span> <span>7 52 A</span> </div>                                                          |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>OTTO BOSIES</b>                                                                                                                                                                                                                                                                  |  | 4. USUAL RESIDENCE [Where deceased lived. If institution: residence before admission]<br>A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>                                                             |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><div style="display: flex; justify-content: space-between;"> <span>90</span> <span>Gould Convalesarium<br/>6116 Belair Road</span> </div>       |  | C. CITY OR TOWN <b>Woodlawn</b> D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                       |  |
| E. STREET AND NUMBER<br><b>7406 Fairbrook Road 21207</b>                                                                                                                                                                                                                                                                   |  | 5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH <b>1/2/88</b> 9. AGE (In years last birthday) <b>83</b>                                                                                                                                                                                                                                                   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Policeman</b>                                                                                 |  |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>                                                                                                                                                                                                                                                                  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                                                                             |  |
| 13. FATHER'S NAME <b>Late John Bosies</b>                                                                                                                                                                                                                                                                                  |  | 14. MOTHER'S MAIDEN NAME <b>Late Pauline Hassman</b>                                                                                                                                                |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>                                                                                                                                                                                                      |  | 16. SOCIAL SECURITY NO. <b>218-36-0348</b>                                                                                                                                                          |  |
| 17. INFORMANT <b>Mrs. Frances Ellis, 7406 Fairbrook Road</b>                                                                                                                                                                                                                                                               |  | ADDRESS                                                                                                                                                                                             |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Asphyxia &amp; Circulatory Collapse</b>                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                        |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Carcinomatous</b>                                                                                                                                                                     |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>Squamous Cell Carcinoma of the Lip</b>                                                         |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Prostate Gland Metastasis, Gastric Emphysema, Generalized Atherosclerosis</b>                                                                                                 |  | 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                    |  |
| 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                                  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                      |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                            |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                   |  | 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                       |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                     |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                          |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/29/71</b> to <b>11/11/71</b> that (I) (we) last saw the deceased alive on <b>11/10/71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                                                                                     |  |
| 23A. SIGNATURE <b>Albert B. Bradley</b>                                                                                                                                                                                                                                                                                    |  | 23B. DATE SIGNED <b>11/11/71</b>                                                                                                                                                                    |  |
| 23C. PHYSICIAN'S NAME (Type) <b>Albert B. Bradley</b>                                                                                                                                                                                                                                                                      |  | 23D. ADDRESS <b>4900 Belair Rd</b>                                                                                                                                                                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                     |  | 24B. DATE <b>11/13/71</b>                                                                                                                                                                           |  |
| 24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>                                                                                                                                                                                                                                                           |  | 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>                                                                                                                            |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 12 1971</b>                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>                                                                                                                                                |  |
| 25C. FUNERAL DIRECTOR <b>Witzke, 1630 Edmondson Ave., 21228</b>                                                                                                                                                                                                                                                            |  | ADDRESS                                                                                                                                                                                             |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

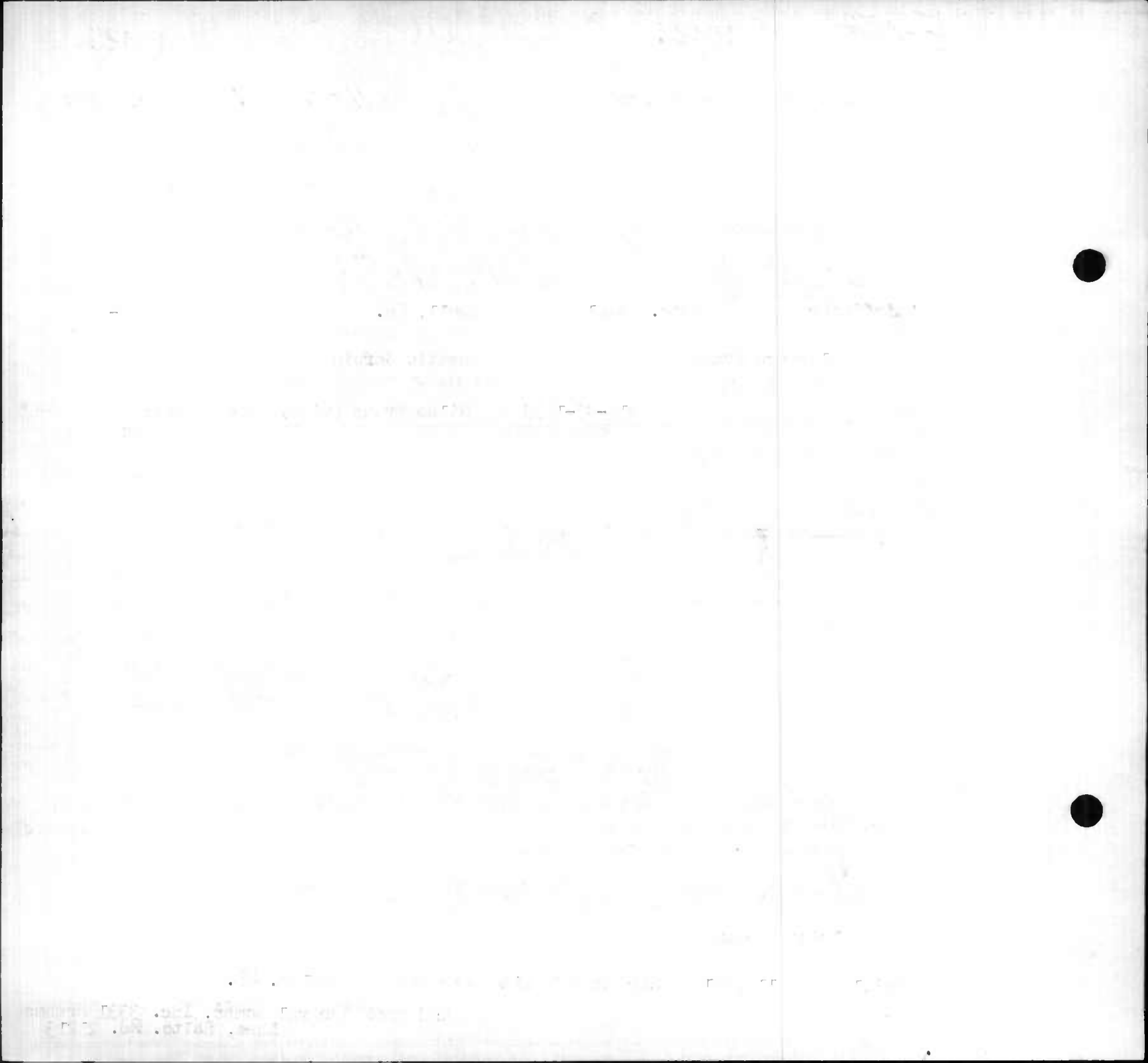
|                                                                                                                                                                                                                                                                                                                                                                                                                          |                      |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                         |                      | REG. NO. <u>71 10424</u>                                                                                                                                                                                                                                                                                                         |                                                                                                                                         |
| 7-426 71 10424                                                                                                                                                                                                                                                                                                                                                                                                           |                      | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                             |                                                                                                                                         |
| 1. NAME OF DECEASED<br>(Type or Print) <b>REGINALDO FOLCARELLI</b>                                                                                                                                                                                                                                                                                                                                                       |                      | 2. DATE AND HOUR OF DEATH<br><b>11-05-71 7:17 P.M.</b>                                                                                                                                                                                                                                                                           |                                                                                                                                         |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>THE JOHNS HOPKINS HOSPITAL<br/>BALTIMORE, MD 21205</b><br><b>33</b>                                                                                                                                                                        |                      | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>702</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>2433 MCELDERRY STREET</b> |                                                                                                                                         |
| 5. SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                       | 6. RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                      | 8. DATE OF BIRTH <b>01-22-94</b><br>9. AGE (In years last birthday) <b>77</b><br>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>                                                                                                                                                                                                                                                                                                             |                      | 10B. KIND OF BUSINESS OR INDUSTRY <b>City of Balto.</b>                                                                                                                                                                                                                                                                          |                                                                                                                                         |
| 11. BIRTHPLACE (State or foreign country) <b>Italy</b>                                                                                                                                                                                                                                                                                                                                                                   |                      | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>                                                                                                                                                                                                                                                                                         |                                                                                                                                         |
| 13. FATHER'S NAME <b>DOMINIC FOLCARELLI</b>                                                                                                                                                                                                                                                                                                                                                                              |                      | 14. MOTHER'S MAIDEN NAME <b>Victoria DeAnglis</b>                                                                                                                                                                                                                                                                                |                                                                                                                                         |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>                                                                                                                                                                                                                                                                                                       |                      | 16. SOCIAL SECURITY NO. <b>215-05-9137</b>                                                                                                                                                                                                                                                                                       |                                                                                                                                         |
| 17. INFORMANT <b>Guendalina Folcarelli (wife)</b>                                                                                                                                                                                                                                                                                                                                                                        |                      | ADDRESS <b>same address</b>                                                                                                                                                                                                                                                                                                      |                                                                                                                                         |
| 18. <b>441.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE <b>Hypotension</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>Aortic Aneurysm</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>Arteriosclerosis</b> |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                     |                                                                                                                                         |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                   |                      |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                         |
| 19A. DATE OF OPERATION <b>3/11/71</b>                                                                                                                                                                                                                                                                                                                                                                                    |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ruptured Aortic Aneurysm</b>                                                                                                                                                                                                                                                 |                                                                                                                                         |
| 20A. AUTOPSY? (Yes or No) <b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                                     |                      | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                             |                                                                                                                                         |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                    |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                         |                                                                                                                                         |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                 |                      | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                        |                                                                                                                                         |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                |                      | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                       |                                                                                                                                         |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11/5/71</b> 19 <b>71</b> to <b>11/5/71</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>11/5/71</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                           |                      |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                         |
| 23A. SIGNATURE <b>J. Lucian Davis</b>                                                                                                                                                                                                                                                                                                                                                                                    |                      | 23B. DATE SIGNED <b>Nov 5, 1971</b>                                                                                                                                                                                                                                                                                              |                                                                                                                                         |
| 23C. PHYSICIAN'S NAME (Type) <b>J. LUCIAN DAVIS M.D.</b>                                                                                                                                                                                                                                                                                                                                                                 |                      | 23D. ADDRESS <b>Johns Hopkins Hospital</b>                                                                                                                                                                                                                                                                                       |                                                                                                                                         |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                   |                      | 24B. DATE <b>11/9/71</b>                                                                                                                                                                                                                                                                                                         |                                                                                                                                         |
| 24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>                                                                                                                                                                                                                                                                                                                                                         |                      | 24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>                                                                                                                                                                                                                                                                  |                                                                                                                                         |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 12 1971</b>                                                                                                                                                                                                                                                                                                                                                                       |                      | 25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>                                                                                                                                                                                                                                                                             |                                                                                                                                         |
| 25C. FUNERAL DIRECTOR <b>Schimunek Funeral Homes, Inc.</b>                                                                                                                                                                                                                                                                                                                                                               |                      | ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>                                                                                                                                                                                                                                                                                |                                                                                                                                         |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                      |                   |                                                                                                                                                                                                                                                                                                  |                           |                                                              |                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|--------------------------------------------------------------|------------------------------------------------------------|
| E-152 71 10425                                                                                                                                                                                                                                                                                                                                       |                   | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                 |                           | REG. NO. 71 10425                                            |                                                            |
| BIRTH NO. Evans, Sherman                                                                                                                                                                                                                                                                                                                             |                   | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                             |                           |                                                              |                                                            |
| 1. NAME OF DECEASED<br>(Type or Print) EVANS, SHERMAN                                                                                                                                                                                                                                                                                                |                   | 2. DATE AND HOUR OF DEATH<br>11-6-71 11 AM M.                                                                                                                                                                                                                                                    |                           |                                                              |                                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>John Hopkins Hospital<br>Cotler 7, Medicine Intensive Care                                                                                                                |                   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 701<br>C. CITY OR TOWN/ Baltimore<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 813 N. Streeter St. |                           |                                                              |                                                            |
| 5. SEX male                                                                                                                                                                                                                                                                                                                                          | 6. RACE caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                      | 8. DATE OF BIRTH 10/18/07 | 9. AGE (In years last birthday) 64                           | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipfitter                                                                                                                                                                                                                                               |                   | 10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel                                                                                                                                                                                                                                                    |                           | 11. BIRTHPLACE (State or foreign country) Ewell, Md.         |                                                            |
| 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                         |                   | 13. FATHER'S NAME Clarence Evans                                                                                                                                                                                                                                                                 |                           |                                                              |                                                            |
| 14. MOTHER'S MAIDEN NAME Hattie Coffin                                                                                                                                                                                                                                                                                                               |                   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no                                                                                                                                                                                      |                           |                                                              |                                                            |
| 16. SOCIAL SECURITY NO. 218-03-1833                                                                                                                                                                                                                                                                                                                  |                   | 17. INFORMANT ADDRESS Hilda Evans (wife) same address                                                                                                                                                                                                                                            |                           |                                                              |                                                            |
| 18. 410.94 1250.9<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTCEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute anterolateral MI<br>(B) ASCVD<br>(C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                 |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>24 hours     |                                                            |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>Diabetes mellitus, anemia                                                                                                                                                                                  |                   | 21 years                                                                                                                                                                                                                                                                                         |                           |                                                              |                                                            |
| 19A. DATE OF OPERATION 2                                                                                                                                                                                                                                                                                                                             |                   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                 |                           | 20A. AUTOPSY? (Yes or No) Yes                                |                                                            |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO                                                                                                                                                                                                                                                                              |                   | (If In Baltimore City, give exact location)                                                                                                                                                                                                                                                      |                           |                                                              |                                                            |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                              |                   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                         |                           | 21C. WHERE DID INJURY OCCUR?                                 |                                                            |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                            |                   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                           |                           | 21F. HOW DID INJURY OCCUR?                                   |                                                            |
| 22. I certify that (I) (this hospital) attended the deceased from October 28 1971 to November 6 1971<br>that (I) (we) last saw the deceased alive on November 6 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                        |                   |                                                                                                                                                                                                                                                                                                  |                           |                                                              |                                                            |
| 23A. SIGNATURE<br>Eloise Harman MD                                                                                                                                                                                                                                                                                                                   |                   | 23B. DATE SIGNED<br>11/6/71                                                                                                                                                                                                                                                                      |                           | 23C. PHYSICIAN'S NAME (Type) Eloise Harman                   |                                                            |
| 23D. ADDRESS                                                                                                                                                                                                                                                                                                                                         |                   | 23E. FUNERAL DIRECTOR<br>Schimmeler Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213                                                                                                                                                                                                       |                           |                                                              |                                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                                      |                   | 24B. DATE 11/9/71                                                                                                                                                                                                                                                                                |                           | 24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cemetery |                                                            |
| 24D. LOCATION (City, town, or county) Balto. Md.                                                                                                                                                                                                                                                                                                     |                   | 24E. STATE (State) Md.                                                                                                                                                                                                                                                                           |                           |                                                              |                                                            |
| 25A. DATE REC'D BY HEALTH DEPT. NOV 12 1971                                                                                                                                                                                                                                                                                                          |                   | 25B. NAME OF REGISTRAR Robert E. Jaber, M.D.                                                                                                                                                                                                                                                     |                           | 25C. FUNERAL DIRECTOR                                        |                                                            |

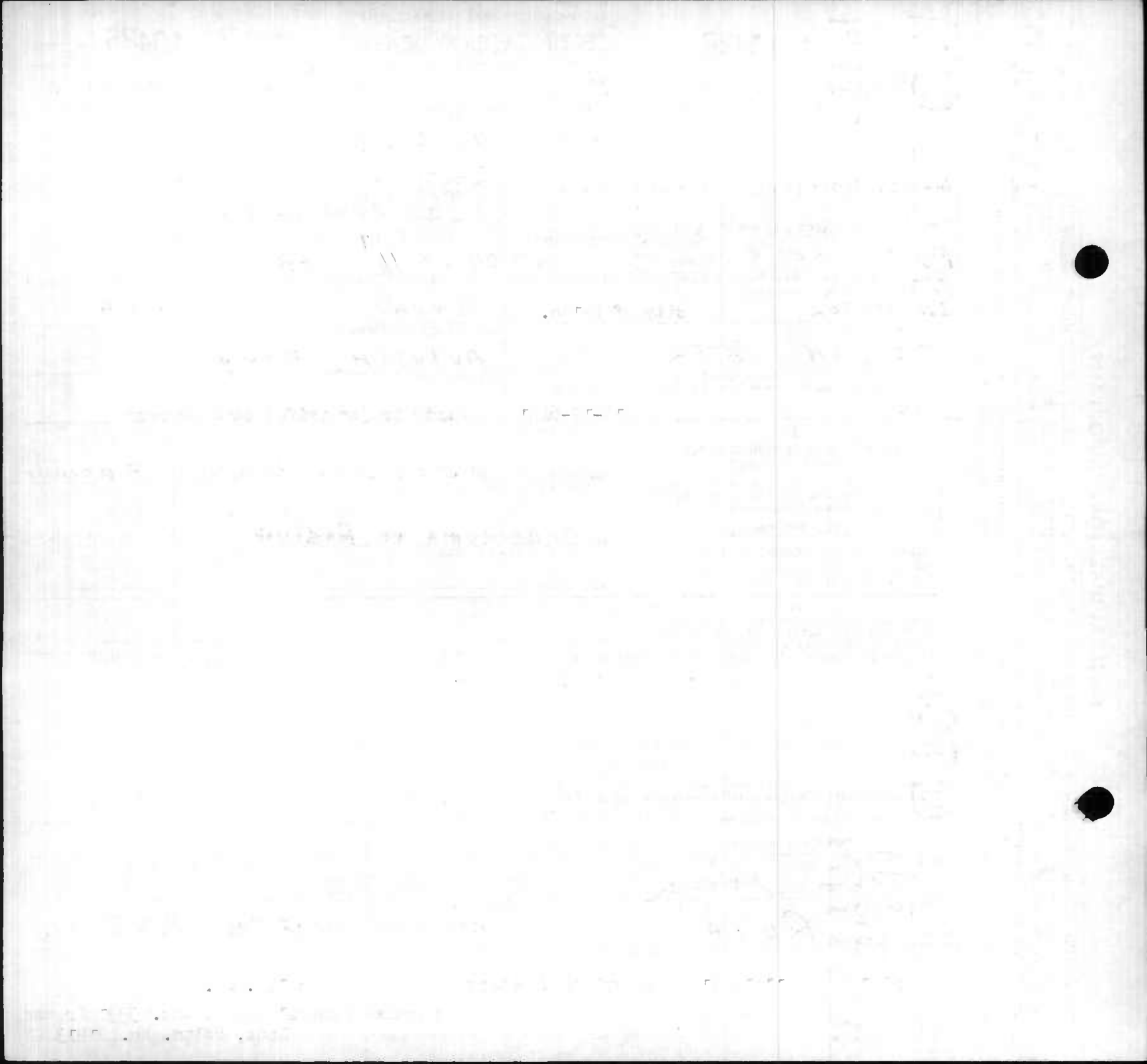




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

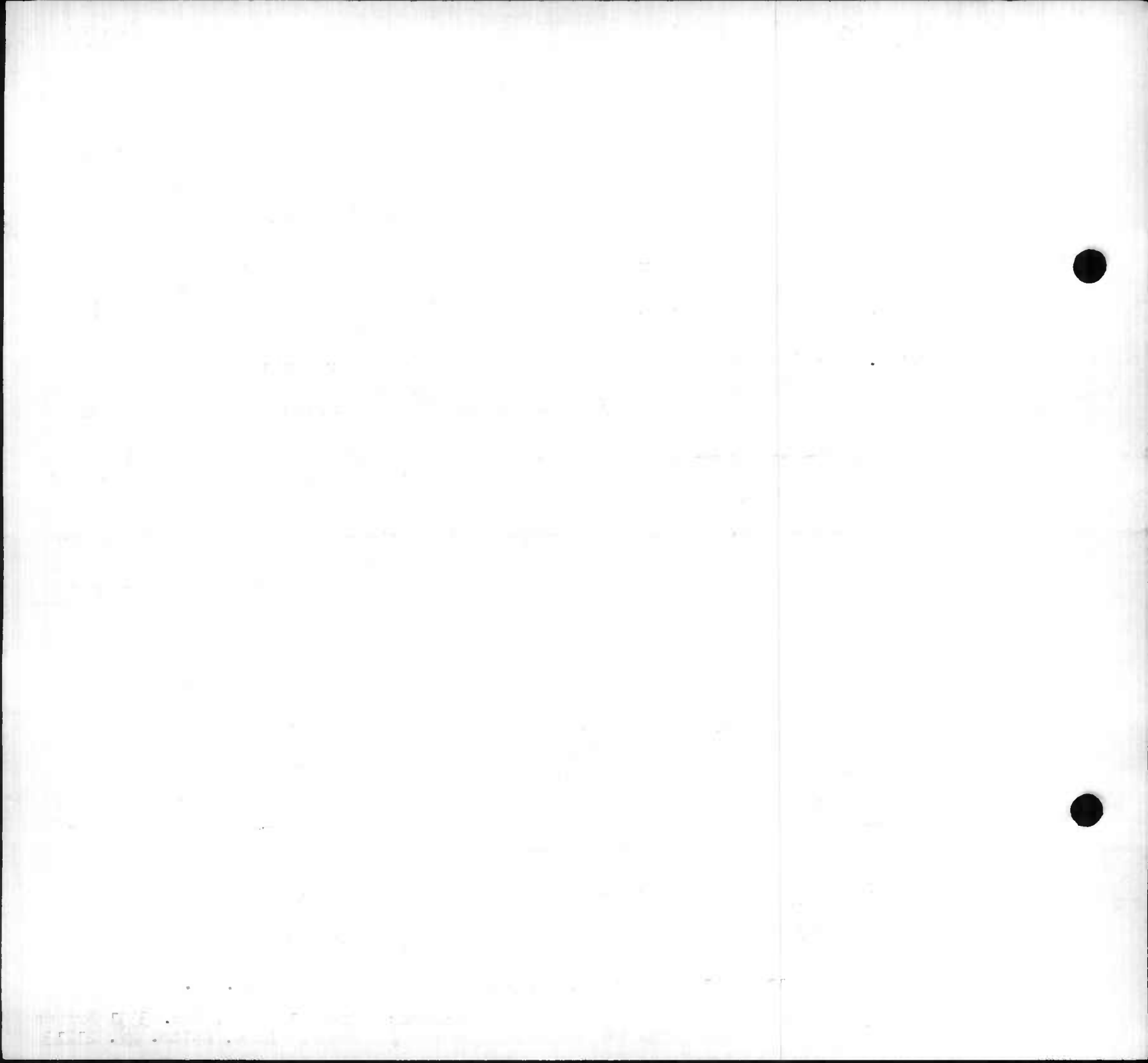
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                |         |                                                                                                        |                  | REG. NO. <u>71 10426</u>                                                 |                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span>T-625 71 10426</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>                                                                                                                                                                        |         |                                                                                                        |                  |                                                                          |                                                                                            |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                          |         | 2. DATE AND HOUR OF DEATH                                                                              |                  |                                                                          |                                                                                            |
| TROJAN, ARTHUR, J                                                                                                                                                                                                                                                                                               |         | 11-07-71 09:00 P.M.                                                                                    |                  |                                                                          |                                                                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                          |         | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)                  |                  |                                                                          |                                                                                            |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                       |         | A. STATE                                                                                               |                  | B. COUNTY                                                                |                                                                                            |
| MERCY HOSPITAL - BALTO. MD.                                                                                                                                                                                                                                                                                     |         | MD                                                                                                     |                  | 2633                                                                     |                                                                                            |
| 37                                                                                                                                                                                                                                                                                                              |         | C. CITY OR TOWN                                                                                        |                  | D. INSIDE CITY LIMITS?                                                   |                                                                                            |
|                                                                                                                                                                                                                                                                                                                 |         | BALTIMORE                                                                                              |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |                                                                                            |
|                                                                                                                                                                                                                                                                                                                 |         | E. STREET AND NUMBER                                                                                   |                  |                                                                          |                                                                                            |
|                                                                                                                                                                                                                                                                                                                 |         | 3229 RAMONA AVE                                                                                        |                  |                                                                          |                                                                                            |
| 5. SEX                                                                                                                                                                                                                                                                                                          | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                  | 8. DATE OF BIRTH | 9. AGE (In years last birthday)                                          | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| MALE                                                                                                                                                                                                                                                                                                            | WHITE   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                     | 07 04-28-71      | 63                                                                       | INSPECTOR                                                                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                     |         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                      |                  | 11. BIRTHPLACE (State or foreign country)                                |                                                                                            |
| INSPECTOR                                                                                                                                                                                                                                                                                                       |         | City of Balto.                                                                                         |                  | PENNA.                                                                   |                                                                                            |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                               |         | 14. MOTHER'S MAIDEN NAME                                                                               |                  | 12. CITIZEN OF WHAT COUNTRY?                                             |                                                                                            |
| TROJAN, PETER                                                                                                                                                                                                                                                                                                   |         | AUTUSTA, MARY                                                                                          |                  | U.S.A.                                                                   |                                                                                            |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                        |         | 16. SOCIAL SECURITY NO.                                                                                |                  | 17. INFORMANT ADDRESS                                                    |                                                                                            |
| no                                                                                                                                                                                                                                                                                                              |         | 218-12-6117                                                                                            |                  | Marie Trojan (wife) same address                                         |                                                                                            |
| 18. 154.1 I                                                                                                                                                                                                                                                                                                     |         | CAUSE OF DEATH                                                                                         |                  |                                                                          |                                                                                            |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                  |         | (A) IMMEDIATE CAUSE MULTIPLE LIVER METASTASIS 8 MONTHS                                                 |                  |                                                                          |                                                                                            |
| [This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.]                                                                                                                                                                    |         | DUE TO, OR AS A CONSEQUENCE OF:                                                                        |                  |                                                                          |                                                                                            |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                               |         | (B) CARCINOMA OF RECTUM                                                                                |                  |                                                                          |                                                                                            |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                       |         | DUE TO, OR AS A CONSEQUENCE OF:                                                                        |                  |                                                                          |                                                                                            |
| (C)                                                                                                                                                                                                                                                                                                             |         |                                                                                                        |                  |                                                                          |                                                                                            |
| II                                                                                                                                                                                                                                                                                                              |         |                                                                                                        |                  |                                                                          |                                                                                            |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                |         |                                                                                                        |                  |                                                                          |                                                                                            |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                          |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                  | 20A. AUTOPSY? (Yes or No)                                                |                                                                                            |
| 105.03.71                                                                                                                                                                                                                                                                                                       |         | CA OF RECTUM                                                                                           |                  | NO                                                                       |                                                                                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                           |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                                            |
|                                                                                                                                                                                                                                                                                                                 |         |                                                                                                        |                  |                                                                          |                                                                                            |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                       |         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                  | 21F. HOW DID INJURY OCCUR?                                               |                                                                                            |
|                                                                                                                                                                                                                                                                                                                 |         |                                                                                                        |                  |                                                                          |                                                                                            |
| 22. I certify that (I) (this hospital) attended the deceased from 8/26/71 19 to 11/7/71 19 that (I) (we) last saw the deceased alive on 11-07-71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |                                                                                                        |                  |                                                                          |                                                                                            |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                  |         |                                                                                                        |                  | 23B. DATE SIGNED                                                         |                                                                                            |
| G. ROCA                                                                                                                                                                                                                                                                                                         |         |                                                                                                        |                  |                                                                          |                                                                                            |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                    |         |                                                                                                        |                  | 23D. ADDRESS                                                             |                                                                                            |
| G. ROCA                                                                                                                                                                                                                                                                                                         |         |                                                                                                        |                  | MERCY HOSPITAL - BALTO. MD                                               |                                                                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                        |         | 24B. DATE                                                                                              |                  | 24C. NAME OF CEMETERY or CREMATORY                                       |                                                                                            |
| Burial                                                                                                                                                                                                                                                                                                          |         | 11/10/71                                                                                               |                  | Meadowridge Cemetery                                                     |                                                                                            |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                 |         | 25B. NAME OF REGISTRAR                                                                                 |                  | 25C. FUNERAL DIRECTOR ADDRESS                                            |                                                                                            |
| NOV 15 1971                                                                                                                                                                                                                                                                                                     |         | D. B. E. Fisher, M.D.                                                                                  |                  | Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213         |                                                                                            |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

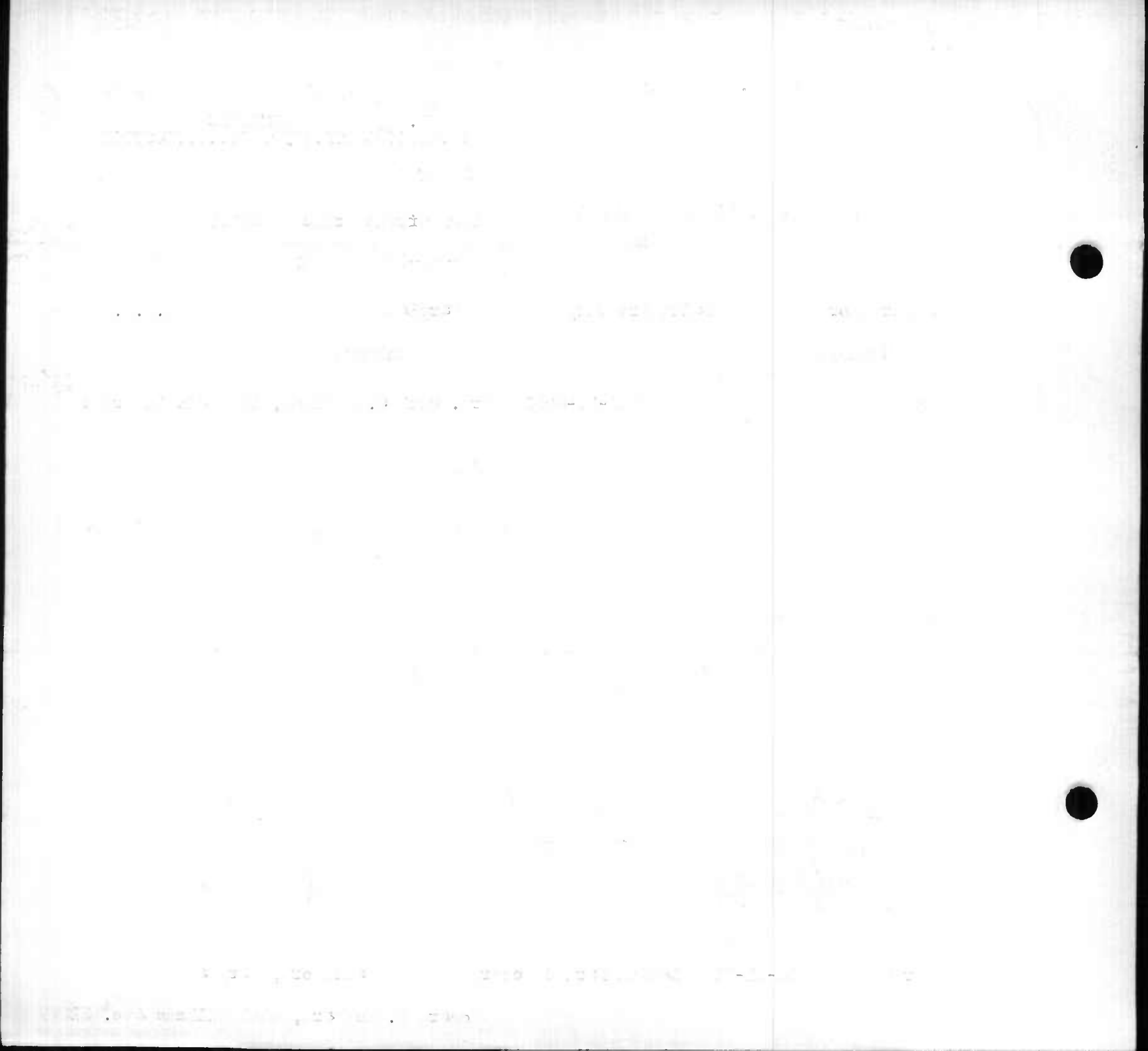
|                                                                                                                                                                                                                                                                                                                                                         |                              |                                                                                                                                                                                                                                                                                                               |                                  |                                                                                                  |                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------|
| A-130 71 10427                                                                                                                                                                                                                                                                                                                                          |                              | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                              |                                  | REG. NO. 71 10427                                                                                |                                           |
| <b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                                                             |                              |                                                                                                                                                                                                                                                                                                               |                                  |                                                                                                  |                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MRS. GLADYS B. ABBOTT</b>                                                                                                                                                                                                                                                                                     |                              | 2. DATE AND HOUR OF DEATH<br><b>11-8-71 12:30 AM.</b>                                                                                                                                                                                                                                                         |                                  |                                                                                                  |                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>MARYLAND GENERAL HOSPITAL<br/>827 LINDEN AVE.<br/>BALTO, MD.</b>                                                                                                          |                              | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>USA</b><br>C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>301 MCMECHAN ST.</b> |                                  |                                                                                                  |                                           |
| 5. SEX <b>F</b>                                                                                                                                                                                                                                                                                                                                         | 6. RACE <b>W</b>             | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                   | 8. DATE OF BIRTH <b>12-31-03</b> |                                                                                                  | 9. AGE (in years last birthday) <b>67</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>                                                                                                                                                                                                                                         |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>HOUSEWIFE</b>                                                                                                                                                                                                                                                         |                                  | 11. BIRTHPLACE (State or foreign country) <b>MD.</b>                                             |                                           |
| 13. FATHER'S NAME<br><b>Chas. BATCHELDER.</b>                                                                                                                                                                                                                                                                                                           |                              | 14. MOTHER'S MAIDEN NAME<br><b>Mary Price</b>                                                                                                                                                                                                                                                                 |                                  |                                                                                                  |                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                   |                              | 16. SOCIAL SECURITY NO.<br><b>215-01-2094</b>                                                                                                                                                                                                                                                                 |                                  | 17. INFORMANT<br><b>PATIENT - FROM OLD RECORD</b>                                                |                                           |
| 18. <b>250.0 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>TOXIC ENCEPHALOPATHY- 3 wks.</b><br><b>ANOXIC</b>                                                                            |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 MONTH</b>                                                                                                                                                                                                                                                |                                  |                                                                                                  |                                           |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>DIABETES MELLITUS</b>                                                                                                                                                                                              |                              | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>U.T.I.</b>                                                                                                                                                                                                                                                          |                                  | (C) <b>25 yrs.</b>                                                                               |                                           |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>II</b>                                                                                                                                                                                                           |                              |                                                                                                                                                                                                                                                                                                               |                                  | <b>1 wk.</b>                                                                                     |                                           |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                      |                              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                              |                                  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                           |                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)<br><b>NO</b>                                                                                                                                                                                                                                                      |                              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                      |                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                         |                                           |
| 21D. TIME OF INJURY (Approx.)                                                                                                                                                                                                                                                                                                                           |                              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                     |                                  | 21F. HOW DID INJURY OCCUR?                                                                       |                                           |
| 22. I certify that (1) (this hospital) attended the deceased from <b>10-33</b> 19 <b>71</b> to <b>11-8</b> 19 <b>71</b> that (1) (we) last saw the deceased alive on <b>11-8-</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |                              |                                                                                                                                                                                                                                                                                                               |                                  |                                                                                                  |                                           |
| 23A. SIGNATURE<br><b>Henry G. Sacks MD</b>                                                                                                                                                                                                                                                                                                              |                              | 23B. DATE SIGNED<br><b>11-8-71</b>                                                                                                                                                                                                                                                                            |                                  |                                                                                                  |                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>HENRY G. SACKS MD</b>                                                                                                                                                                                                                                                                                                |                              | 23D. ADDRESS<br><b>MARYLAND GENERAL HOSPITAL</b>                                                                                                                                                                                                                                                              |                                  |                                                                                                  |                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                               | 24B. DATE<br><b>11/10/71</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                                                                                                                                                                                                                                             |                                  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>                               |                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b>                                                                                                                                                                                                                                                                                                   |                              | 25B. NAME OF REGISTRAR<br><b>P. S. J. J. J.</b>                                                                                                                                                                                                                                                               |                                  | 25C. FUNERAL DIRECTOR<br><b>Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213</b> |                                           |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                 |                     |                                                                                                                                                             |  | CERTIFICATE OF DEATH                                                                                                                                                                           |                                              | REG. NO. 71 10428                                                                             |                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------|
| BIRTH NO. <b>A-325</b>                                                                                                                                                                                                                                                                                                                                                           |                     | 71 10428                                                                                                                                                    |  |                                                                                                                                                                                                |                                              |                                                                                               |                             |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Edward R. Addison</b>                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br><b>11/9/71 11:30 P.M.</b>                                                                                                                                         |                                              |                                                                                               |                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>45 The Good Samaritan Hospital</b>                                                                                                                                                                 |                     |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b><br><del>XXXXXXXXXXXXXXXXXXXXXXXXXXXX</del> <b>5300</b> |                                              |                                                                                               |                             |
|                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             |  | C. CITY OR TOWN<br><b>ARBUTUS</b>                                                                                                                                                              |                                              | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                             |
|                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             |  | E. STREET AND NUMBER<br><b>1009 Circle Drive 21227</b>                                                                                                                                         |                                              |                                                                                               |                             |
| 5. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                               | 6. RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>03-31-92</b>                                                                                                                                                            | 9. AGE (in years last birthday)<br><b>78</b> | If Under 1 Yr. Months Days                                                                    | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Supervisor</b>                                                                                                                                                                                                                                                                 |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Baltimore City</b>                                                                                                  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                   |                                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                 |                             |
| 13. FATHER'S NAME<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>                                                                                                                                                     |                                              |                                                                                               |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                            |                     | 16. SOCIAL SECURITY NO.<br><b>216-20-0937</b>                                                                                                               |  | 17. INFORMANT<br><b>Mrs. Ruth C. Addison, 1009 Circle Drive</b>                                                                                                                                |                                              |                                                                                               |                             |
|                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             |  | ADDRESS <b>21227</b>                                                                                                                                                                           |                                              |                                                                                               |                             |
| 18. <b>185X I</b> CAUSE OF DEATH<br><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     |                                                                                                                                                             |  | (A) IMMEDIATE CAUSE <b>Carcinomatosis</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                   |                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>18 mon.</b>                                |                             |
|                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             |  | (B) <b>Carcinoma of the prostate</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                        |                                              | <b>30 mon</b>                                                                                 |                             |
|                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             |  | (C) _____                                                                                                                                                                                      |                                              |                                                                                               |                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                           |                     |                                                                                                                                                             |  |                                                                                                                                                                                                |                                              |                                                                                               |                             |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                               |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                                                                                                                         |                                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                       |                                              |                                                                                               |                             |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                        |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                     |                                              |                                                                                               |                             |
| 22. I certify that <b>W</b> (this hospital) attended the deceased from <b>10/4/71</b> 19__ to <b>11/9/71</b> 19__ that (I) <b>(we)</b> last saw the deceased alive on <b>11/9/71</b> 19__ and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> (did not) view the body after death.                       |                     |                                                                                                                                                             |  |                                                                                                                                                                                                |                                              |                                                                                               |                             |
| 23A. SIGNATURE<br><b>Paul E. Edgar</b>                                                                                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                             |  | 23B. DATE SIGNED<br><b>11/9/71</b>                                                                                                                                                             |                                              | 23C. PHYSICIAN'S NAME (Type)<br><b>Robert E. Edgar, M.D.</b>                                  |                             |
|                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             |  | 23D. ADDRESS<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>                                                                                                                              |                                              |                                                                                               |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                        |                     | 24B. DATE<br><b>11-13-71</b>                                                                                                                                |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Loudon Park Cemetery</b>                                                                                                                              |                                              | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                   |                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b>                                                                                                                                                                                                                                                                                                                            |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Edgar, M.D.</b>                                                                                                      |  | 25C. FUNERAL DIRECTOR<br><b>Howard H. Hubbard</b>                                                                                                                                              |                                              | ADDRESS<br><b>4107 Wilkens Ave. 21229</b>                                                     |                             |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                              |         |                                                                                                  |                  |                                                                                                          |                             |                                                                      |  |                                                                                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------|-----------------------------|----------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|
| C-452                                                                                                                                        |         | 71 10429                                                                                         |                  | BALTIMORE CITY HEALTH DEPARTMENT                                                                         |                             | X                                                                    |  | 71 10429                                                                              |  |
| BIRTH NO.                                                                                                                                    |         | 1. NAME OF DECEASED<br>(Type or Print)                                                           |                  | 2. DATE AND HOUR OF DEATH                                                                                |                             | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD               |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |  |
|                                                                                                                                              |         | LEANDER COLLINS                                                                                  |                  | 11/8/71 2:15 P.M.                                                                                        |                             |                                                                      |  | A. STATE MARYLAND B. COUNTY HARFORD 6200                                              |  |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                         |         | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                             |                  | C. CITY OR TOWN                                                                                          |                             | D. INSIDE CITY LIMITS?                                               |  |                                                                                       |  |
| 33 JOHNS HOPKINS HOSPITAL                                                                                                                    |         | BALTIMORE MD                                                                                     |                  | HAVRE DE GRACE                                                                                           |                             | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                                                                                       |  |
| E. STREET AND NUMBER                                                                                                                         |         |                                                                                                  |                  | 140 ST JOHN STREET                                                                                       |                             |                                                                      |  |                                                                                       |  |
| 5. SEX                                                                                                                                       | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday)                                                                          | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min.                                         |  |                                                                                       |  |
| M                                                                                                                                            | N       | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                               | 02-17-10         | 61                                                                                                       |                             |                                                                      |  |                                                                                       |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                  |         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                |                  | 11. BIRTHPLACE (State or foreign country)                                                                |                             | 12. CITIZEN OF WHAT COUNTRY?                                         |  |                                                                                       |  |
| Laborer                                                                                                                                      |         | Contractor                                                                                       |                  | Harford County, Maryland                                                                                 |                             | U.S.                                                                 |  |                                                                                       |  |
| 13. FATHER'S NAME                                                                                                                            |         | 14. MOTHER'S MAIDEN NAME                                                                         |                  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |                             | 16. SOCIAL SECURITY NO.                                              |  | 17. INFORMANT ADDRESS                                                                 |  |
| ROBERT COLLINS                                                                                                                               |         | HARRIETT BOND                                                                                    |                  | No                                                                                                       |                             | 244-14-0885                                                          |  | Hattie Collins 140 St. John St. Havre de Grace                                        |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                           |         | CAUSE OF DEATH                                                                                   |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                             |                             |                                                                      |  |                                                                                       |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) |         | Hypoxia                                                                                          |                  | 4 HRS                                                                                                    |                             |                                                                      |  |                                                                                       |  |
| ANTECEDENT CAUSES                                                                                                                            |         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                              |                  |                                                                                                          |                             |                                                                      |  |                                                                                       |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                    |         | METASTASIS TO TRACHEA                                                                            |                  | 6 M                                                                                                      |                             |                                                                      |  |                                                                                       |  |
|                                                                                                                                              |         | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                              |                  |                                                                                                          |                             |                                                                      |  |                                                                                       |  |
|                                                                                                                                              |         | ESOPHAGEAL CARCINOMA                                                                             |                  | 1 YR                                                                                                     |                             |                                                                      |  |                                                                                       |  |
|                                                                                                                                              |         | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                              |                  |                                                                                                          |                             |                                                                      |  |                                                                                       |  |
|                                                                                                                                              |         | INT. VENA CAVAE OBSTRUCTION                                                                      |                  |                                                                                                          |                             |                                                                      |  |                                                                                       |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).             |         |                                                                                                  |                  |                                                                                                          |                             |                                                                      |  |                                                                                       |  |
| 19A. DATE OF OPERATION                                                                                                                       |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                 |                  | 20A. AUTOPSY? (Yes or No)                                                                                |                             | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                                                                       |  |
| D                                                                                                                                            |         |                                                                                                  |                  | NO                                                                                                       |                             |                                                                      |  |                                                                                       |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                        |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)         |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                 |                             |                                                                      |  |                                                                                       |  |
|                                                                                                                                              |         |                                                                                                  |                  |                                                                                                          |                             |                                                                      |  |                                                                                       |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                |         | 21E. INJURY OCCURRED                                                                             |                  | 21F. HOW DID INJURY OCCUR?                                                                               |                             |                                                                      |  |                                                                                       |  |
|                                                                                                                                              |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                |                  |                                                                                                          |                             |                                                                      |  |                                                                                       |  |
| 22. I certify that (I) (this hospital) attended the deceased from                                                                            |         | 11/2 1971 to                                                                                     |                  | 11/8 1971                                                                                                |                             |                                                                      |  |                                                                                       |  |
| that (I) (we) last saw the deceased alive on                                                                                                 |         | 11/8 1971                                                                                        |                  | and that in (my) (our) opinion death occurred on the date                                                |                             |                                                                      |  |                                                                                       |  |
| and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                               |         |                                                                                                  |                  |                                                                                                          |                             |                                                                      |  |                                                                                       |  |
| 23A. SIGNATURE                                                                                                                               |         | 23B. DATE SIGNED                                                                                 |                  | 23C. PHYSICIAN'S NAME (Type)                                                                             |                             | 23D. ADDRESS                                                         |  |                                                                                       |  |
| Keith L. Klein MD                                                                                                                            |         | 11/8/71                                                                                          |                  | KEITH L. KLEIN                                                                                           |                             | Johns Hopkins Hosp Balt Md.                                          |  |                                                                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                     |         | 24B. DATE                                                                                        |                  | 24C. NAME OF CEMETERY or CREMATORY                                                                       |                             | 24D. LOCATION (City, town, or county) (State)                        |  |                                                                                       |  |
| Burial                                                                                                                                       |         | 13 Nov. 71                                                                                       |                  | Greenspring Methodist                                                                                    |                             | Havre de Grace, Rural, Maryland                                      |  |                                                                                       |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                              |         | 25B. NAME OF REGISTRAR                                                                           |                  | 25C. FUNERAL DIRECTOR                                                                                    |                             | ADDRESS                                                              |  |                                                                                       |  |
| NOV 12 1971                                                                                                                                  |         | Robert E. Fisher, M.D.                                                                           |                  | Tarring Funeral Home                                                                                     |                             | S. Parke St. Aberdeen, Md.                                           |  |                                                                                       |  |

XX

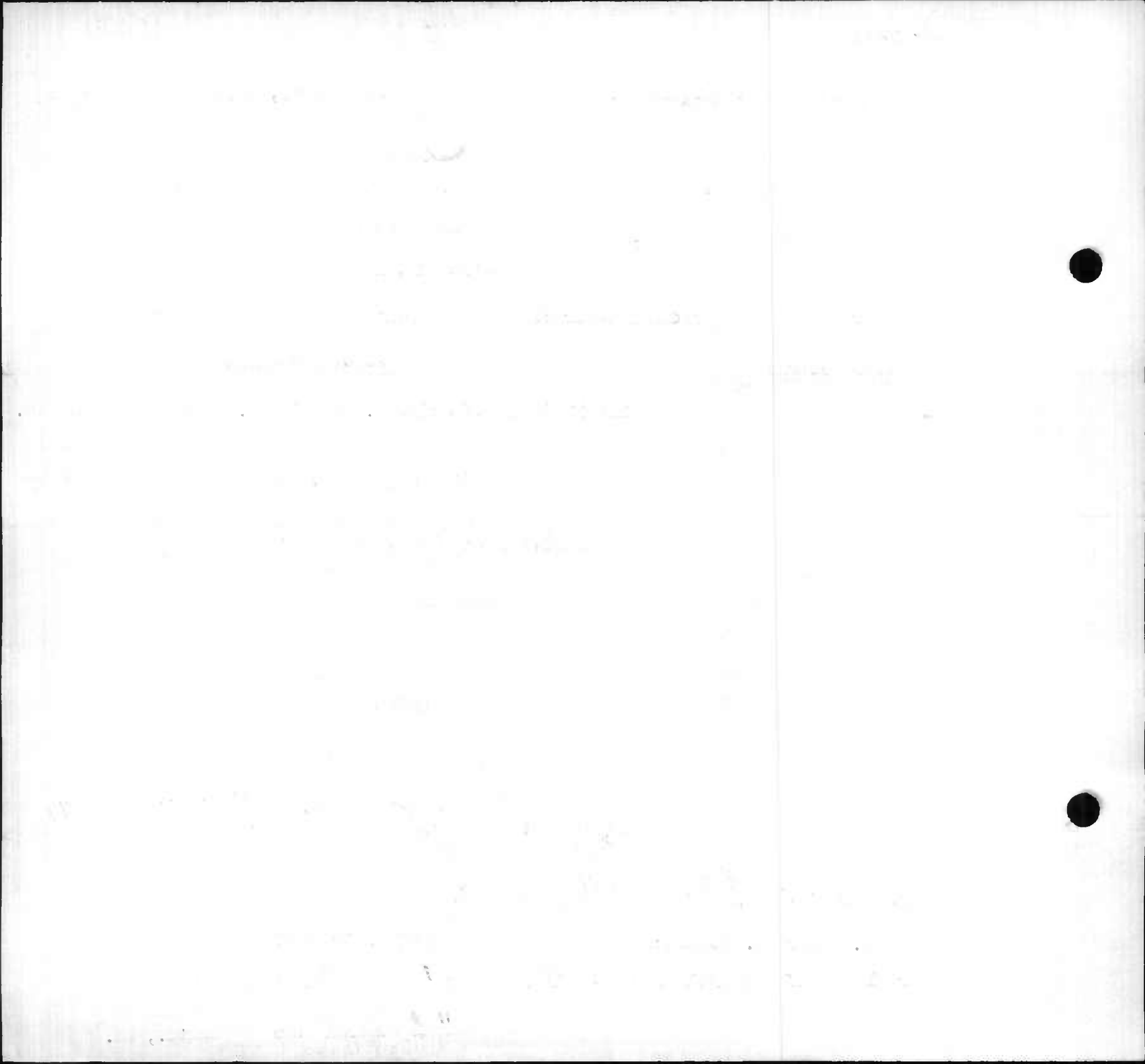
212-01-020



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

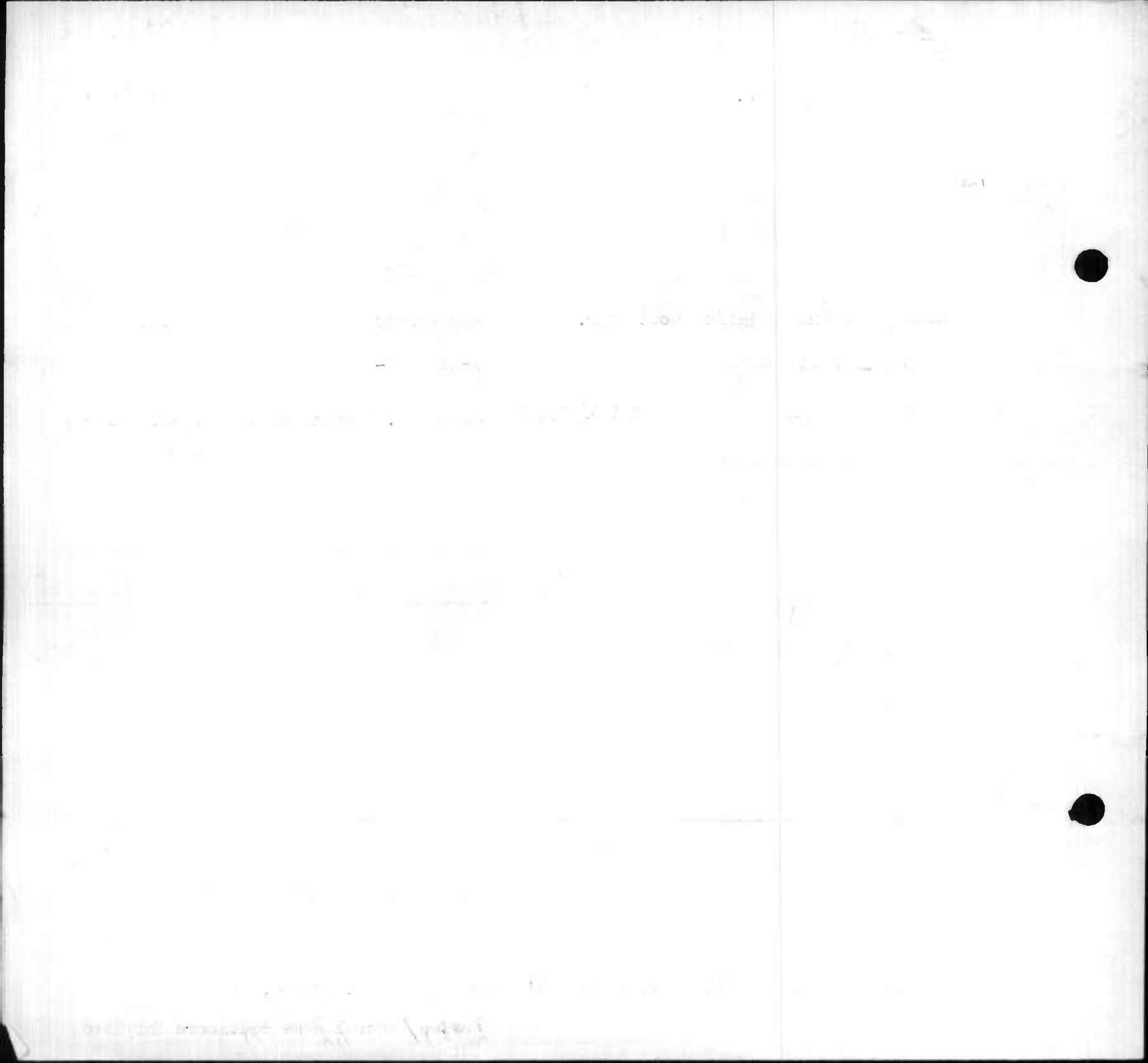
| D-366 71 10430                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                    |                                                                                                                                                                                                                                                                                                                                     | 71 10430<br>REG. NO.                                                     |                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Nicholas A. Detorie Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>November 9, 1971 3:00 A.M.</b>                                                                                                                                                                                                                                                                      |                                                                          |                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 4406 Buena Vista Avenue</b>                                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2765</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>4406 Buena Vista Avenue</b> |                                                                          |                                           |
| 5. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 6. RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                                                                                                                                                                                                     | 8. DATE OF BIRTH<br><b>March 17, 1890</b>                                | 9. AGE (In years last birthday) <b>81</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Roofer</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Roofing Contractor</b>                                                                                              |                                                                                                                                                                                                                                                                                                                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>             |                                           |
| 13. FATHER'S NAME<br><b>John Detorie</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Metrangle</b>                                                                                                                                                                                                                                                                              |                                                                          |                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                     | 16. SOCIAL SECURITY NO.<br><b>218 32 5261</b>                                                                                                               |                                                                                                                                                                                                                                                                                                                                     | 17. INFORMANT<br><b>Nicholas A. Detorie Jr. 1411 Grandview Ave.</b>      |                                           |
| 18. <b>410.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>AC. myocardial infarction</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF</b><br><b>(B) antihypertensive coronary Ar. Dis -</b><br><b>(C)</b> |                     |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3-4 Hrs</b>                                                                                                                                                                                                                                                                      |                                                                          |                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                     |                                                                          |                                           |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                                                     | 20A. AUTOPSY? (Yes or No)                                                |                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                                                                                                                                                                     | 21F. HOW DID INJURY OCCUR?                                               |                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Nov 8 1971</b> to <b>Nov 9 1971</b> that (I) (we) last saw the deceased alive on <b>Nov 8 1971</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                        |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                     |                                                                          |                                           |
| 23A. SIGNATURE<br><b>Edward L. Glassman, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                     | 23B. DATE SIGNED<br><b>11/11/71</b>                                      |                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. Edward L. Glassman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                     | 23D. ADDRESS<br><b>4037 Falls Road</b>                                   |                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     | 24B. DATE<br><b>12 Nov 1971</b>                                                                                                                             |                                                                                                                                                                                                                                                                                                                                     | 24C. NAME OF CEMETERY or CREMATORY<br><b>New Cathedral Cemetery</b>      |                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                     | 24D. LOCATION<br><b>Baltimore, Maryland</b>                              |                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     | 25B. NAME OF REGISTRAR<br><b>E. J. Baker, M.D.</b>                                                                                                          |                                                                                                                                                                                                                                                                                                                                     | 25C. FUNERAL DIRECTOR<br><b>Burgee Funeral Home</b>                      |                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                     | ADDRESS<br><b>Balto., Md.</b>                                            |                                           |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                      |                             |                                                                                                                                                             |                                                                                                                         | 71 10431                                                                 |                                                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |                             |                                                                                                                                                             |                                                                                                                         | REG. NO. 71 10431                                                        |                                                                                        |
| BIRTH NO. <b>G-630</b>                                                                                                                                                                                                                                                                                                                                |                             | 71 10431                                                                                                                                                    |                                                                                                                         |                                                                          |                                                                                        |
| 1. NAME OF DECEASED<br>(Type or Print) <b>JAMES J. GARRETT</b>                                                                                                                                                                                                                                                                                        |                             |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>NOV 5th 1971 3:20 P.M.</b>                                                              |                                                                          |                                                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                |                             |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE _____ B. COUNTY _____ |                                                                          |                                                                                        |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>SINAI HOSPITAL OF BALTIMORE, INC</b>                                                                                                                                                                                                                                                                       |                             |                                                                                                                                                             | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                     |                                                                          |                                                                                        |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                  |                             |                                                                                                                                                             | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |                                                                          |                                                                                        |
| E. STREET AND NUMBER<br><b>1208 W. 36th St. #11</b>                                                                                                                                                                                                                                                                                                   |                             |                                                                                                                                                             |                                                                                                                         |                                                                          |                                                                                        |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                 | 6. RACE<br><b>CAUCASIAN</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/14/26</b>                                                                                      | 9. AGE (In years last birthday)<br><b>45</b>                             | 10. Under 1 Yr. Months: _____ Days: _____<br>11. Under 24 Hrs. Hours: _____ Min: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Sewing Machine Mechanic Coat Mfr.</b>                                                                                                                                                                                                               |                             |                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><b>New Jersey</b>                                                          |                                                                          |                                                                                        |
| 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                     |                             |                                                                                                                                                             | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                              |                                                                          |                                                                                        |
| 13. FATHER'S NAME<br><b>George Garrett</b>                                                                                                                                                                                                                                                                                                            |                             |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>Lena -</b>                                                                               |                                                                          |                                                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes WW II</b>                                                                                                                                                                                                                          |                             |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>157 14 7940</b>                                                                           |                                                                          |                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                       |                             |                                                                                                                                                             | 17. INFORMANT<br><b>Carolyn V. Garrett 1208 West 36th Street</b>                                                        |                                                                          |                                                                                        |
| 18. <b>171.9 I</b> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                     |                             |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                            |                                                                          |                                                                                        |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                        |                             |                                                                                                                                                             | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF: <b>Possible Myocardial Infarction 2-3 hours</b>                  |                                                                          |                                                                                        |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                        |                             |                                                                                                                                                             | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                     |                                                                          |                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                       |                             |                                                                                                                                                             | (C) <b>Rabdomiosarcoma? 4 months</b>                                                                                    |                                                                          |                                                                                        |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                |                             |                                                                                                                                                             |                                                                                                                         |                                                                          |                                                                                        |
| 19A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                    |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                         | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>                                  |                                                                                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                 |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                     |                                                                                                                         | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                                        |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                             |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                         | 21F. HOW DID INJURY OCCUR?                                               |                                                                                        |
| 22. I certify that (I) (this hospital) attended the deceased from <b>November 4th 1971</b> to <b>November 5th 1971</b> that (I) (we) last saw the deceased alive on <b>November 5th 1971</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                             |                                                                                                                                                             |                                                                                                                         |                                                                          |                                                                                        |
| 23A. SIGNATURE<br><b>Mirelman</b>                                                                                                                                                                                                                                                                                                                     |                             |                                                                                                                                                             | 23B. DATE SIGNED<br><b>November 5th 1971</b>                                                                            |                                                                          |                                                                                        |
| 23C. PHYSICIAN'S NAME (Type)<br><b>DANIEL MIRELMAN</b>                                                                                                                                                                                                                                                                                                |                             |                                                                                                                                                             | 23D. ADDRESS<br><b>SINAI HOSPITAL OF BALTIMORE</b>                                                                      |                                                                          |                                                                                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                             |                             | 24B. DATE<br><b>10 Nov 71</b>                                                                                                                               |                                                                                                                         | 24C. NAME OF CEMETERY or CREMATORY<br><b>Gettysburg Nat'l Cem</b>        |                                                                                        |
| 24D. LOCATION<br><b>Gettysburg, Pa</b>                                                                                                                                                                                                                                                                                                                |                             | 24E. LOCATION (City, town, or county) (State)                                                                                                               |                                                                                                                         |                                                                          |                                                                                        |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b>                                                                                                                                                                                                                                                                                                 |                             | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>                                                                                                     |                                                                                                                         | 25C. FUNERAL DIRECTOR<br><b>Bureau Funeral Home Baltimore Maryland</b>   |                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                       |                             | 25D. NAME OF REGISTRAR                                                                                                                                      |                                                                                                                         | 25E. FUNERAL DIRECTOR                                                    |                                                                                        |

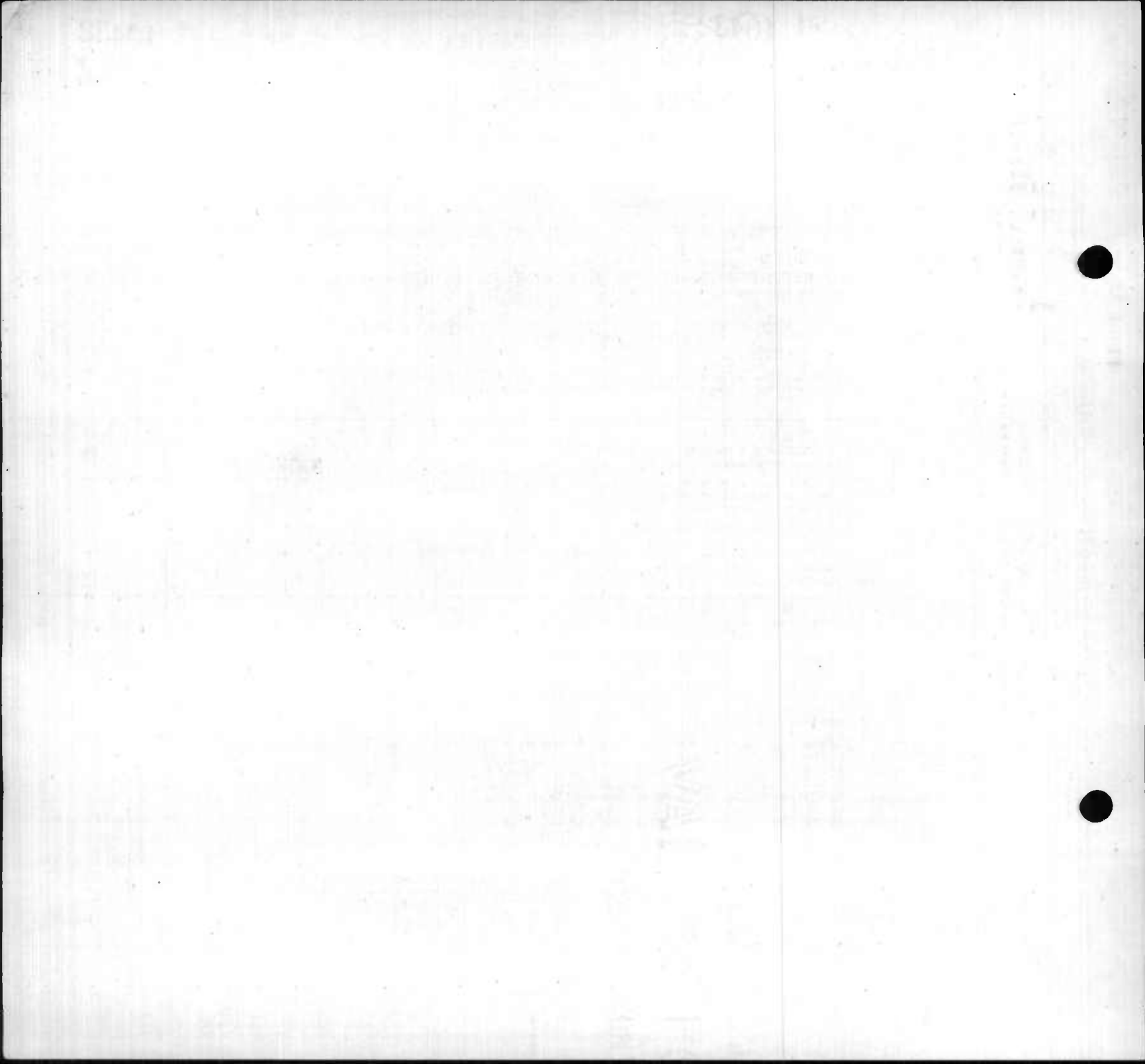


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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underdetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                                                                                                                                                                                                 |                                    |                                                                                                  |                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. <b>R-53871 10432</b>                                                                                                                                                                                                                                                                                                                                                                                                     |                         | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                |                                    | REG. NO. <b>71 10432</b>                                                                         |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <b>B/B of Katherine Randall</b>                                                                                                                                                                                                                                                                                                                                                             |                         | 2. DATE AND HOUR OF DEATH<br><b>11/10/71 4:40 a. M.</b>                                                                                                                                                                                                                                                                         |                                    |                                                                                                  |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>33 The Johns Hopkins Hospital</b>                                                                                                                                                                                                                    |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundle 5200</b><br>C. CITY OR TOWN <b>Friendship</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>Rt. #2 Friendship, Md.</b> |                                    |                                                                                                  |                                                           |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                              | 6. RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                     | 8. DATE OF BIRTH<br><b>11/7/71</b> | 9. AGE (In years last birthday)<br><b>3 1/4</b>                                                  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                        |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                               |                                    | 11. BIRTHPLACE (State or foreign country)                                                        |                                                           |
| 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 13. FATHER'S NAME<br><b>Charles Randall</b>                                                                                                                                                                                                                                                                                     |                                    |                                                                                                  |                                                           |
| 14. MOTHER'S MAIDEN NAME<br><b>Katherine Gross</b>                                                                                                                                                                                                                                                                                                                                                                                 |                         | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                        |                                    |                                                                                                  |                                                           |
| 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 17. INFORMANT ADDRESS                                                                                                                                                                                                                                                                                                           |                                    |                                                                                                  |                                                           |
| 18. <b>778.2 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>PULMONARY &amp; INTRAVENTRICULAR HEMORRHAGE</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>PREMATURITY</b> |                         | CAUSE OF DEATH<br><b>PULMONARY &amp; INTRAVENTRICULAR HEMORRHAGE</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>PREMATURITY</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C).....                                                                                                                            |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b>                                    |                                                           |
| 19. <b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                  |                         | <b>HYALINE MEMBRANE DISEASE</b>                                                                                                                                                                                                                                                                                                 |                                    |                                                                                                  |                                                           |
| 19A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                |                                    | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>                                                          |                                                           |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>                                                                                                                                                                                                                                                                                                                                                     |                         | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                         |                                    |                                                                                                  |                                                           |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                           |                         | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                        |                                    |                                                                                                  |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                          |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                       |                                    | 21F. HOW DID INJURY OCCUR?                                                                       |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>NOV 7</b> 1971 to <b>NOV 10</b> 1971, that (I) (we) last saw the deceased alive on <b>NOV 10</b> 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                |                         |                                                                                                                                                                                                                                                                                                                                 |                                    |                                                                                                  |                                                           |
| 23A. SIGNATURE<br><b>T. G. Quattlebaum, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                                                                                                                                                                                                 |                                    | 23B. DATE SIGNED<br><b>NOV 10, 1971</b>                                                          |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>T. G. Quattlebaum, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                                                                                                                                                                                                 |                                    | 23D. ADDRESS<br><b>The Johns Hopkins Hospital</b>                                                |                                                           |
| 24A. BURIAL CREMATION REMOVAL (Specify)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                        |                         | 24B. DATE<br><b>11/10/71</b>                                                                                                                                                                                                                                                                                                    |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><b>The Johns Hopkins Hosp. 601 N. Broadway Balto., MD.</b> |                                                           |
| 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                      |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b>                                                                                                                                                                                                                                                                           |                                    |                                                                                                  |                                                           |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Jaber, R.A.</b>                                                                                                                                                                                                                                                                                                                                                                             |                         | 25C. FUNERAL DIRECTOR ADDRESS<br><b>HOSPITAL DISPOSAL</b>                                                                                                                                                                                                                                                                       |                                    |                                                                                                  |                                                           |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                                                                                         |                                      |                                                                                                                             |                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| C-640 71 10433                                                                                                                                                                                                                                                                                                                                          |                         | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                |                                      | REG. NO. 71 10433                                                                                                           |                                                           |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                               |                         | 1. NAME OF DECEASED<br>(Type or Print) <u>John H. Crowley</u>                                                                                                                                                           |                                      | 2. DATE AND HOUR OF DEATH<br><u>11/11/71</u> <u>3.30 p.</u> M.                                                              |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                  |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Baltimore, Md.</u><br>B. COUNTY <u>2301</u>                                                                        |                                      | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>South Baltimore General Hospital</u>                                                                                                                                                                                                                                                                         |                         | E. STREET AND NUMBER<br><u>1415 Race St., Baltimore, Md 21230</u>                                                                                                                                                       |                                      |                                                                                                                             |                                                           |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                                                                   | 6. RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                             | 8. DATE OF BIRTH<br><u>2/15/1884</u> | 9. AGE (In years last birthday)<br><u>87</u>                                                                                | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Boiler Worker Md. Drydock</u>                                                                                                                                                                                                                 |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Md.</u>                                                                                                                                                                         |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>                                                                                 |                                                           |
| 13. FATHER'S NAME<br><u>Frederick Dec.</u>                                                                                                                                                                                                                                                                                                              |                         | 14. MOTHER'S MAIDEN NAME<br><u>Mary E. Jones Dec.</u>                                                                                                                                                                   |                                      |                                                                                                                             |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                   |                         | 16. SOCIAL SECURITY NO.<br><u>214 03 2134</u>                                                                                                                                                                           |                                      | 17. INFORMANT<br><u>Mrs. Viola C. Heinz Box 402 Rt. 2</u>                                                                   |                                                           |
| 18. <u>1971.8 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         | CAUSE OF DEATH<br><u>Bayside Beach Pasadena, Md</u><br>(A) IMMEDIATE CAUSE<br><u>Cancer of Liver</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>with distant metastasis</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                |                                                           |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                        |                         |                                                                                                                                                                                                                         |                                      |                                                                                                                             |                                                           |
| 19A. DATE OF OPERATION<br><u>2</u>                                                                                                                                                                                                                                                                                                                      |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                        |                                      | 20A. AUTOPSY? (Yes or No)<br><u>YES</u>                                                                                     |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                                                                                 |                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                    |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                               |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                               |                                      | 21F. HOW DID INJURY OCCUR?                                                                                                  |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/28</u> 19 <u>71</u> to <u>11/11</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11/11</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                                                                                         |                                      |                                                                                                                             |                                                           |
| 23A. SIGNATURE<br><u>W. E. Jones</u>                                                                                                                                                                                                                                                                                                                    |                         | 23B. DATE SIGNED<br><u>11/11/71</u>                                                                                                                                                                                     |                                      |                                                                                                                             |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Cesar Hidalgo</u>                                                                                                                                                                                                                                                                                                    |                         | 23D. ADDRESS<br><u>South Baltimore General Hospital</u>                                                                                                                                                                 |                                      |                                                                                                                             |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                               |                         | 24B. DATE<br><u>11/13/71</u>                                                                                                                                                                                            |                                      | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Olivet Cemetery</u>                                                            |                                                           |
| 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Maryland</u>                                                                                                                                                                                                                                                                             |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 12 1971</u>                                                                                                                                                                   |                                      | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, M.D.</u>                                                                     |                                                           |
| 25C. FUNERAL DIRECTOR<br><u>George J. Conner</u>                                                                                                                                                                                                                                                                                                        |                         | 25D. ADDRESS<br><u>4001</u>                                                                                                                                                                                             |                                      | 25E. SIGNATURE<br><u>R. E. Taylor</u>                                                                                       |                                                           |

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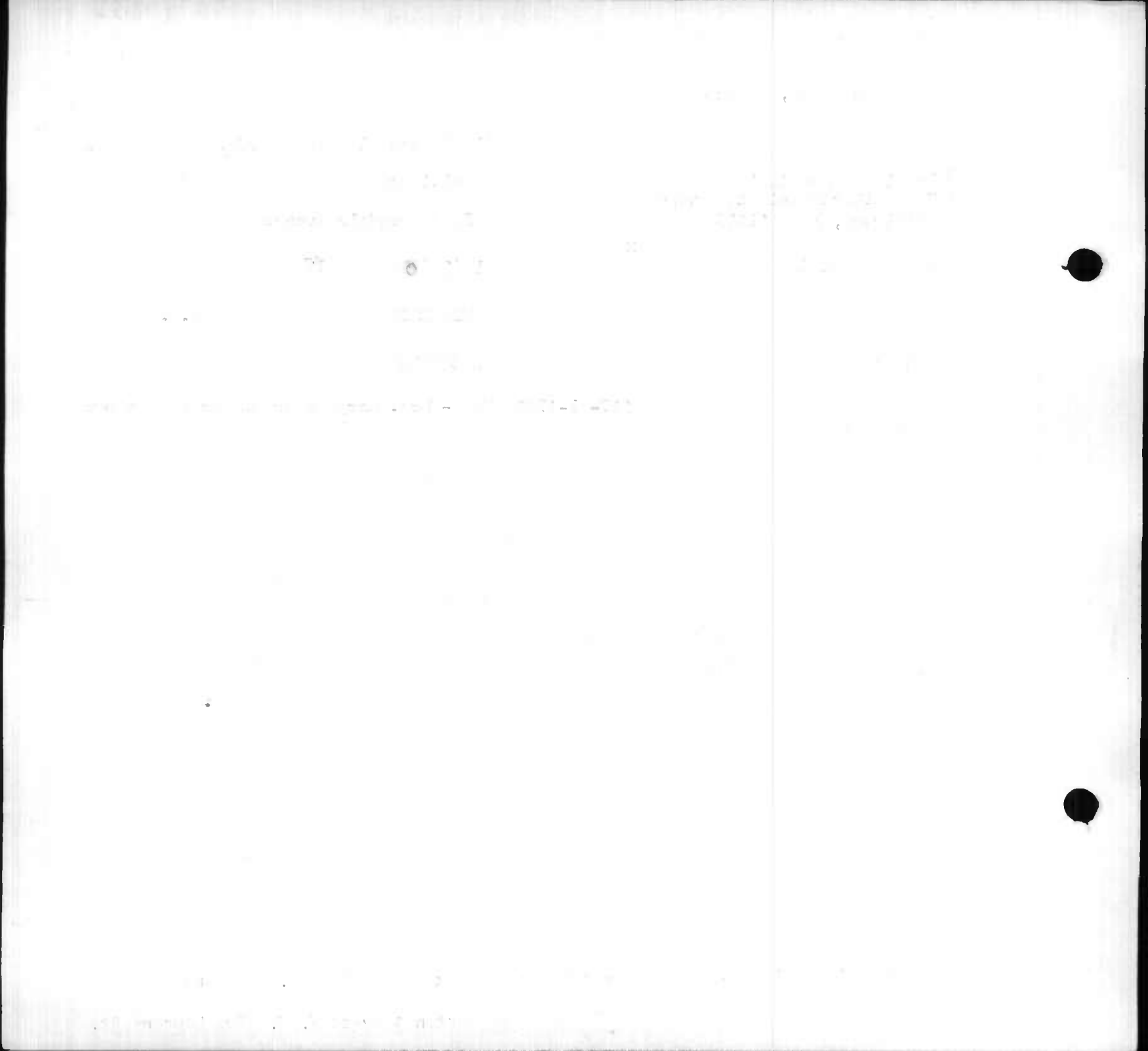
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                                                                                                                                           | REG. NO.                                                          |                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------------|
| A-536 71 10434                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                                                                                                                                           | 71 10434                                                          |                                                        |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |                                                                                                                                                           | 1                                                                 |                                                        |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ANDERSON, McCoy</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>11-10-71</b> <b>8:00 P.M.</b>                                                                                             |                                                                   |                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>(3809 Ferndale Ave)</b> |                                                                   |                                                        |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Provident Hospital<br/>2600 Liberty Heights Avenue<br/>Baltimore, MD 21215</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                                                   |                                                        |
| E. STREET AND NUMBER<br><b>3809 Ferndale Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                                                                                                                                           |                                                                   |                                                        |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 6. RACE<br><b>BLACK</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/20/04</b>                                                                                                                       | 9. AGE (In years last birthday)<br><b>67</b>                      | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>                                                                                              |                                                                   |                                                        |
| 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                                               |                                                                   |                                                        |
| 13. FATHER'S NAME<br><b>DECEASED</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>DECEASED</b>                                                                                                               |                                                                   |                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>217-07-4752</b>                                                                                                             |                                                                   |                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             | 17. INFORMANT ADDRESS<br><b>WIFE- Mrs. Mary Anderson same as above</b>                                                                                    |                                                                   |                                                        |
| 18. <b>582X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br><b>ASHD</b><br><b>Ch. Renal failure</b><br><b>Antecedent Causes</b><br><b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b><br><b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> |                         |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                              |                                                                   |                                                        |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                          |                                                                   |                                                        |
| 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                      |                                                                   |                                                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                  |                                                                   |                                                        |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                                                                                                                                           |                                                                   |                                                        |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                    |                                                                   |                                                        |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                                                                                                                                           |                                                                   |                                                        |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                                                                                                                                           |                                                                   |                                                        |
| 23A. SIGNATURE<br><b>MC Mercado MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 23B. DATE SIGNED                                                                                                                                          |                                                                   |                                                        |
| 23C. PHYSICIAN'S NAME (Type)<br><b>MANUEL G. MERCADO MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             | 23D. ADDRESS<br><b>PROVIDENT HOSP. BALTO. MD 21215</b>                                                                                                    |                                                                   |                                                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 24B. DATE<br><b>11-15-71</b>                                                                                                                                |                                                                                                                                                           | 24C. NAME OF CEMETERY or CREMATORY<br><b>Carver Memorial Park</b> |                                                        |
| 24D. LOCATION<br><b>Laurel, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 24E. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b>                                                                                                       |                                                                                                                                                           |                                                                   |                                                        |
| 24F. NAME OF REGISTRAR<br><b>Robert E. Dyett</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | 24G. FUNERAL DIRECTOR ADDRESS<br><b>Morton &amp; Dyett F. H. 1701 Laurens St.</b>                                                                           |                                                                                                                                                           |                                                                   |                                                        |



| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                             |                                                                                                                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                             |                                                                                                                                                                          |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                             | REG. NO.                                                                                                                                                                 |  |
| 1. NAME OF DECEASED<br>(Type or Print) HARVEY J. LEWIS                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                             | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> Hour M.                                                          |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>00 433 Oxford Ct.                                                                                                                                                                                                                      |                                                                                                                                                             | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour M.<br>November 9, 1971                                                                                                    |  |
| 6. SEX Male                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                             | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 1702                                                |  |
| 7. RACE Negro                                                                                                                                                                                                                                                                                                                                                                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                  |  |
| 9. DATE OF BIRTH 3-13-1902                                                                                                                                                                                                                                                                                                                                                                                    | 10. AGE (In years last birthday) 68<br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.                                                               | E. STREET AND NUMBER 433 Oxford Ct.                                                                                                                                      |  |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md.                                                                                                                                                                                                                                                                                                                                                      | 12. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                                                         | 13. FATHER'S NAME Dennis Lewis                                                                                                                                           |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                   | 14B. KIND OF BUSINESS OR INDUSTRY Waiter                                                                                                                    | 15. MOTHER'S MAIDEN NAME Martha Lewis                                                                                                                                    |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No                                                                                                                                                                                                                                                                                                    | 17. SOCIAL SECURITY NO. 218-18-5942                                                                                                                         | 18. INFORMANT ADDRESS<br>Mr. Williams J. Lewis 2442 Edmondson Ave.                                                                                                       |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic cardiovascular disease                                                                                                                                                                   |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                             |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                |                                                                                                                                                             | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                              |                                                                                                                                                             | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                      |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                             | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                         |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                          |                                                                                                                                                             | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                 |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                             | 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)                                                                                                           |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                        |                                                                                                                                                             | 22F. HOW DID INJURY OCCUR?                                                                                                                                               |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                                                                                                                                             |                                                                                                                                                                          |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                             | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                             | 24B. DATE 11-12-71                                                                                                                                                       |  |
| 24C. NAME OF CEMETERY or CREMATORY Western Star Cemetery                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                             | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland                                                                                                        |  |
| 25A. DATE REC'D BY HEALTH DEPT. NOV 12 1971                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                             | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D.                                                                                                                            |  |
| 25C. FUNERAL DIRECTOR Morton & Dyett F. H.                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                             | 25D. ADDRESS 1701 Laurens St.                                                                                                                                            |  |

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                          |  |                                                                                                                                                             |  | REG. NO.                                      |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                          |  |                                                                                                                                                             |  |                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                    |  | Sloan E Gingles                                                                          |  |                                                                                                                                                             |  |                                               |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                            |  | 46 Lutheran Hosp                                                                         |  |                                                                                                                                                             |  |                                               |  |
| 6. SEX                                                                                                                                                                                                                                                                                                                                                                                                    |  | 7. RACE                                                                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. DATE OF BIRTH                              |  |
| M                                                                                                                                                                                                                                                                                                                                                                                                         |  | Neg                                                                                      |  |                                                                                                                                                             |  | 1-29-1905                                     |  |
| 10. AGE (In years, months, days, hours, minutes)                                                                                                                                                                                                                                                                                                                                                          |  | 11. BIRTHPLACE (State or foreign country)                                                |  | 12. CITIZEN OF WHAT COUNTRY                                                                                                                                 |  | 13. FATHER'S NAME                             |  |
| 66                                                                                                                                                                                                                                                                                                                                                                                                        |  | Gastonia N.C.                                                                            |  | U.S.A.                                                                                                                                                      |  | Ballif Gingles                                |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                               |  | 14B. KIND OF BUSINESS OR INDUSTRY                                                        |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                    |  |                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                          |  | Sarah Elizabeth Scott                                                                                                                                       |  |                                               |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                   |  | 17. SOCIAL SECURITY NO.                                                                  |  | 18. INFORMANT                                                                                                                                               |  | ADDRESS                                       |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                        |  | 615-07-2058                                                                              |  | Beatrice Gingles                                                                                                                                            |  | 2234 Penrose Ave.                             |  |
| 19. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                             |  |                                                                                                                                                             |  |                                               |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                              |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |  |                                                                                                                                                             |  |                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                           |  | Arteriosclerotic                                                                         |  |                                                                                                                                                             |  |                                               |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                            |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                      |  |                                                                                                                                                             |  |                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                           |  | Coronary Vascular Disease                                                                |  |                                                                                                                                                             |  |                                               |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                          |  | (C)                                                                                      |  |                                                                                                                                                             |  |                                               |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                    |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  |                                                                                                                                                             |  |                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                          |  |                                                                                                                                                             |  |                                               |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                      |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                    |  |                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                          |  |                                                                                                                                                             |  |                                               |  |
| 22D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                                             |  | 22E. INJURY OCCURRED                                                                     |  | 22F. HOW DID INJURY OCCUR?                                                                                                                                  |  |                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                           |  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>        |  |                                                                                                                                                             |  |                                               |  |
| 23.                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                          |  |                                                                                                                                                             |  |                                               |  |
| I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                          |  |                                                                                                                                                             |  |                                               |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                          |  | EXAMINER'S NAME (Type)                                                                   |  | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                                                  |  | DATE SIGNED                                   |  |
| Werner H. Spitz                                                                                                                                                                                                                                                                                                                                                                                           |  | M.D.                                                                                     |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                                                                                         |  | 11. 7. 71                                     |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                  |  | 24B. DATE                                                                                |  | 24C. NAME OF CEMETERY or CREMATORY                                                                                                                          |  | 24D. LOCATION (City, town, or county) (State) |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                    |  | 11-11-71                                                                                 |  | Arbutus MmPk                                                                                                                                                |  | Baltimore, Md                                 |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                                                                                           |  | 25B. NAME OF REGISTRAR                                                                   |  | 25C. FUNERAL DIRECTOR                                                                                                                                       |  | ADDRESS                                       |  |
| NOV 12 1971                                                                                                                                                                                                                                                                                                                                                                                               |  | Robert E. Barber, R.D.                                                                   |  | Morton Dyett F.H.                                                                                                                                           |  | 1701 - Laurens St                             |  |



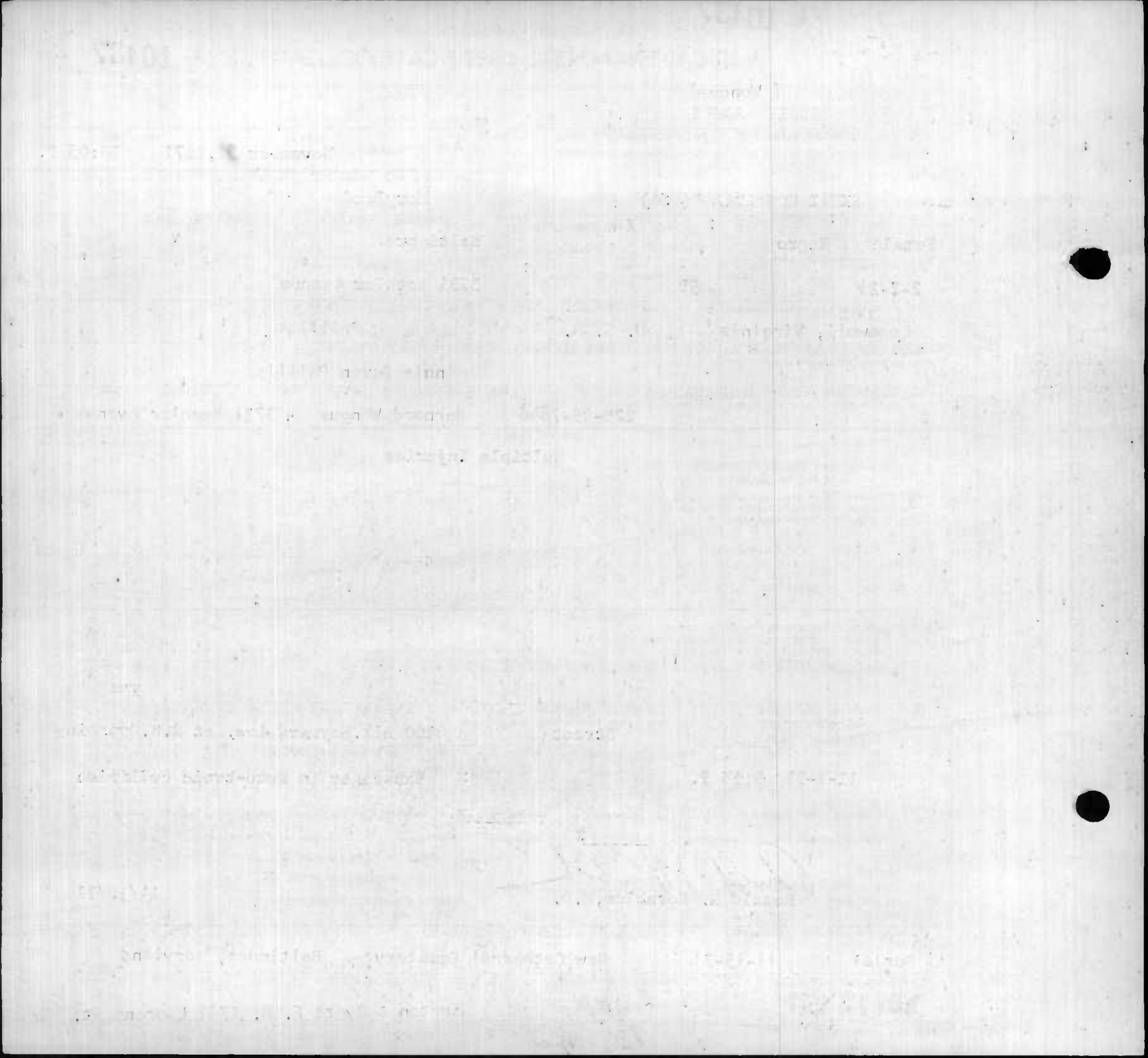
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10437

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print)<br><b>ESSIE JONES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> Hour M.                                                  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>SINAI HOSPITAL (DOA)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>November 9, 1971 10:05 P.</b>                                                                               |  |
| 6. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 7. RACE<br><b>Negro</b>                                                                                                                                          |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                              |  |
| 9. DATE OF BIRTH<br><b>2-2-21</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10. AGE (In years last birthday)<br><b>50</b>                                                                                                                    |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Hopewell, Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                                  |  |
| 13. FATHER'S NAME<br><b>Phillips</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                    |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br><b>Minnie Green Phillips</b>                                                                                                         |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 17. SOCIAL SECURITY NO.<br><b>229-05-7846</b>                                                                                                                    |  |
| 18. INFORMANT<br><b>Bernard Wongus</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | ADDRESS<br><b>3731 Beehler Avenue</b>                                                                                                                            |  |
| 19. <b>E 810.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CAUTION LAST.                                                                                                                                                                                                                                                                                                                                             |  | CAUSE OF DEATH<br><b>Multiple Injuries</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                     |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                 |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Street</b>                                                        |  |
| 22D. TIME OF INJURY (APPROX.)<br><b>11-9-71 9:15 P.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                             |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>4100 Blk. Hayward Ave. at R.R. Crossing</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 22F. HOW DID INJURY OCCUR?<br><b>Passenger in auto-train collision</b>                                                                                           |  |
| 23.<br>I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>11/10/71</b><br>EXAMINER'S NAME (Type) |  |                                                                                                                                                                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 24B. DATE<br><b>11-15-71</b>                                                                                                                                     |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>New Cathedral Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                                                                                      |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>                                                                                                          |  |
| 25C. FUNERAL DIRECTOR<br><b>Morton &amp; Dyett F. H.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | ADDRESS<br><b>1701 Laurens St.</b>                                                                                                                               |  |







FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     |                                                                                                                                                             |  | CERTIFICATE OF DEATH                                                                                                                                                                 |                                            | REG. NO. <u>71 10438</u>                                                                      |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-----------------------------------------------------------------------------------------------|--|
| BIRTH NO. <u>7-426 71 10438</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Alice Fulgum (Fulgum)</u>                                                                                                                  |                                            | 2. DATE AND HOUR OF DEATH<br><u>11-10-71</u> <u>4</u> <u>A.</u> M.                            |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION <u>90 HOUSE OF PINES NURSING HOME</u><br>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION                                                                                                                                                                                                                                                                                                          |                     |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)<br>A. STATE <u>MD.</u> B. COUNTY <u>1608</u>                                                  |                                            |                                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |  | C. CITY OR TOWN<br><u>BALTIMORE</u>                                                                                                                                                  |                                            | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |  | E. STREET AND NUMBER<br><u>702 Edgewood St.</u>                                                                                                                                      |                                            |                                                                                               |  |
| 5. SEX<br><u>F</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 6. RACE<br><u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>2-25-87</u>                                                                                                                                                   | 9. AGE in years last birthday<br><u>84</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                             |                     | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |  | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore, Maryland</u>                                                                                                              |                                            | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>                                               |  |
| 13. FATHER'S NAME<br><u>Joseph Demby</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><u>Rebecca Demby</u>                                                                                                                                     |                                            |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                |                     | 16. SOCIAL SECURITY NO.                                                                                                                                     |  | 17. INFORMANT<br><u>Delores Hicks</u> ADDRESS <u>702 Edgewood St.</u>                                                                                                                |                                            |                                                                                               |  |
| 18. <u>412.3 I</u> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                     |                                                                                                                                                             |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Myocardial infarction</u><br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><u>Coronary artery disease</u><br><br>(C) _____ |                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |  |                                                                                                                                                                                      |                                            |                                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |  |                                                                                                                                                                                      |                                            |                                                                                               |  |
| 19A. DATE OF OPERATION<br><u>11/9</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                                            |                                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                             |                                            |                                                                                               |  |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                           |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                           |                                            |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11/9</u> 19 <u>71</u> to <u>11/19/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11/9</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did not) view the body after death.                                                                                                                                                                     |                     |                                                                                                                                                             |  |                                                                                                                                                                                      |                                            |                                                                                               |  |
| 23A. SIGNATURE<br><u>William Wilson</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                                                                                                                                                             |  | 23B. DATE SIGNED<br><u>11/10/71</u>                                                                                                                                                  |                                            | 23C. PHYSICIAN'S NAME (Type)<br><u>WILSON</u>                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |  | 23D. ADDRESS<br><u>5721 Oakley (Hylton)</u>                                                                                                                                          |                                            |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     | 24B. DATE<br><u>11-15-71</u>                                                                                                                                |  | 24C. NAME of CEMETERY or CREMATORY<br><u>Mt. Auburn Cemetery</u>                                                                                                                     |                                            | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Maryland</u>                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 12 1971</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     | 25B. NAME OF REGISTRAR<br><u>Robert E. Garber, M.D.</u>                                                                                                     |  | 25C. FUNERAL DIRECTOR<br><u>Morton &amp; Dyett F. H.</u> ADDRESS <u>1701 Laurens St.</u>                                                                                             |                                            |                                                                                               |  |

Prunella

Cardinal with bloom

15/10/11, 15

15/11

15

15/10/11

Cardinal (1st)

15/11

Prunella  
15/11/11

C-616 71 10439

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 10439 REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>CHARLES W. CRAWFORD, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.                |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>1117 S. Hanover Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>November 11, 1971 7:40 A. M.                                                 |  |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7. RACE<br>Negro                                                                                                               |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | C. CITY OR TOWN<br>Baltimore                                                                                                   |  |
| 9. DATE OF BIRTH<br>10/25/1900                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10. AGE (In years last birthday)<br>71                                                                                         |  |
| 11. BIRTHPLACE (State or foreign country)<br>Lancaster, Pa.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                            |  |
| 13. FATHER'S NAME<br>Wm Crawford                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Noted: 1002 Market Baltimore Co. |  |
| 15. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                  |  |
| 17. SOCIAL SECURITY NO.<br>212 14 8132                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 18. INFORMANT<br>1117 S Hanover                                                                                                |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic cardiovascular disease<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                   |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                               |  |
| 21. AUTOPSY? (Yes or No)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                       |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                      |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 22F. HOW DID INJURY OCCUR?                                                                                                     |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE Charles S. Springate, M.D.<br>EXAMINER'S NAME (Type) Charles S. Springate, M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 11, 1971 |  |                                                                                                                                |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 24B. DATE<br>11/15/71                                                                                                          |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Mt Auburn                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 24D. LOCATION (City, town or county) (State)<br>Baltimore                                                                      |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 12 1971                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, M.D.                                                                               |  |
| 25C. FUNERAL DIRECTOR<br>Marshall P. Hays                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 25D. ADDRESS<br>6819 Gile                                                                                                      |  |

10432

10432

Wm. M. Brown  
Treasurer

| BIRTH NO.                                                                                                                                                                                    |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                     |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                              |  | REG. NO. 71 10440                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                       |  | WILLIE R. WILLIAMS                                                                                                                                                                                   |  | 2. DATE OF DEATH                                                                                                                                                                                     |  | Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> November 11, 1971 |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                       |  | 00 2600 Block Beryl Avenue (street)                                                                                                                                                                  |  | 3. DATE PRONOUNCED DEAD                                                                                                                                                                              |  | Month Day Year<br>November 11, 1971 1:35 A.M.                                                         |  |
| 6. SEX                                                                                                                                                                                       |  | 7. RACE                                                                                                                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                          |  | C. CITY OR TOWN                                                                                       |  |
| Male                                                                                                                                                                                         |  | Negro                                                                                                                                                                                                |  |                                                                                                                                                                                                      |  | Baltimore                                                                                             |  |
| 9. DATE OF BIRTH                                                                                                                                                                             |  | 10. AGE (in years last birthday)                                                                                                                                                                     |  | 11. BIRTHPLACE (State or foreign country)                                                                                                                                                            |  | 12. CITIZEN OF WHAT COUNTRY?                                                                          |  |
| Feb 8 - 1916                                                                                                                                                                                 |  | 55                                                                                                                                                                                                   |  | Sussex Co Va                                                                                                                                                                                         |  | USA                                                                                                   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                  |  | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                             |  | 13. FATHER'S NAME                                                                                     |  |
| Laborer                                                                                                                                                                                      |  | Beth Steel Co Full Balland                                                                                                                                                                           |  | Nathan Williams                                                                                                                                                                                      |  |                                                                                                       |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                      |  | 17. SOCIAL SECURITY NO.                                                                                                                                                                              |  | 18. INFORMANT                                                                                                                                                                                        |  | ADDRESS                                                                                               |  |
|                                                                                                                                                                                              |  |                                                                                                                                                                                                      |  | Williams Family                                                                                                                                                                                      |  | Petersburg Va                                                                                         |  |
| 19. E965X 1                                                                                                                                                                                  |  | CAUSE OF DEATH                                                                                                                                                                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                         |  |                                                                                                       |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                               |  | Gunshot wound of right thigh                                                                                                                                                                         |  |                                                                                                       |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                               |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                  |  |                                                                                                                                                                                                      |  |                                                                                                       |  |
| (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                          |  |                                                                                                                                                                                                      |  |                                                                                                                                                                                                      |  |                                                                                                       |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                             |  |                                                                                                                                                                                                      |  |                                                                                                                                                                                                      |  |                                                                                                       |  |
| 20A. DATE OF OPERATION                                                                                                                                                                       |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                     |  | 21. AUTOPSY? (Yes or No)                                                                                                                                                                             |  |                                                                                                       |  |
| 2                                                                                                                                                                                            |  |                                                                                                                                                                                                      |  | Yes                                                                                                                                                                                                  |  |                                                                                                       |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                              |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                             |  | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                             |  |                                                                                                       |  |
|                                                                                                                                                                                              |  |                                                                                                                                                                                                      |  | 0000                                                                                                                                                                                                 |  |                                                                                                       |  |
| 22D. TIME OF INJURY (APPROX.)                                                                                                                                                                |  | 22E. INJURY OCCURRED                                                                                                                                                                                 |  | 22F. HOW DID INJURY OCCUR?                                                                                                                                                                           |  |                                                                                                       |  |
| 11-11-71                                                                                                                                                                                     |  | approx. 1:15 A.M.<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                    |  | Shot by unknown assailant                                                                                                                                                                            |  |                                                                                                       |  |
| 23.                                                                                                                                                                                          |  | I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: |  | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                       |  |
| ACTUAL SIGNATURE                                                                                                                                                                             |  | Charles S. Springate M.D.                                                                                                                                                                            |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                                                                                                      |  | DATE SIGNED                                                                                           |  |
| EXAMINER'S NAME (Type)                                                                                                                                                                       |  | Charles S. Springate, M.D.                                                                                                                                                                           |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                                                                                       |  | November 11, 1971                                                                                     |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                     |  | 24B. DATE                                                                                                                                                                                            |  | 24C. NAME of CEMETERY or CREMATORY                                                                                                                                                                   |  | 24D. LOCATION (City, town, or county) (State)                                                         |  |
| Removal                                                                                                                                                                                      |  | 11/12/71                                                                                                                                                                                             |  | Williams Family                                                                                                                                                                                      |  | Sussex Co. Va                                                                                         |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                              |  | 25B. NAME OF REGISTRAR                                                                                                                                                                               |  | 25C. FUNERAL DIRECTOR                                                                                                                                                                                |  | ADDRESS                                                                                               |  |
| NOV 12 1971                                                                                                                                                                                  |  | Robert E. Taylor, M.D.                                                                                                                                                                               |  | Wm Bland F.W. Petersburg Va.                                                                                                                                                                         |  |                                                                                                       |  |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 71 10441                                                                                                                                                                                                                                                                                                                                         |                                   | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                    |                                                                                                                                                                                                                                                                                                                                                              | REG. NO. 71 10441                                                                                     |                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>LOUISE G. KEMPEL</b>                                                                                                                                                                                                                                                                                             |                                   |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>11-10-71 (Wed.) 10:15 P.M.</b>                                                                                                                                                                                                                                                                                               |                                                                                                       |                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>South Baltimore General Hospital<br/>3001 S. Hanover St.<br/>Baltimore, Md. 21230.</b>                                                                                       |                                   |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>B. COUNTY</b><br><b>1325 S. Charles St. Balt. Md. 2302</b><br>C. CITY OR TOWN <b>Baltimore, Md. 21230</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1325 S. CHARLES ST.</b> |                                                                                                       |                                                             |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                    | 6. RACE<br><b>White</b>           | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>AUG 26-1893</b>                                                                                                                                                                                                                                                                                                                       | 9. AGE (in years last birthday)<br><b>78</b>                                                          | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret. Saleslady</b>                                                                                                                                                                                                                                       |                                   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>5810 East St.</b>                                                                                                   | 11. BIRTHPLACE (State or foreign country)<br><b>GERMANY - BALTIMORE, MD.</b>                                                                                                                                                                                                                                                                                 |                                                                                                       | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                  |
| 13. FATHER'S NAME<br><b>CHARLES Wm. Kempele</b>                                                                                                                                                                                                                                                                                                            |                                   |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>KATHERINE PRINCE (PRINZ)</b>                                                                                                                                                                                                                                                                                                  |                                                                                                       |                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                      |                                   | 16. SOCIAL SECURITY NO.<br><b>212-01-5812</b>                                                                                                               | 17. INFORMANT ADDRESS<br><b>Louise C. Hengberger - 562 Rosaglening Rd. 21132</b>                                                                                                                                                                                                                                                                             |                                                                                                       |                                                             |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                                   |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                                                 |                                                                                                       |                                                             |
| (A) IMMEDIATE CAUSE <b>HEMORRHAGE INTO AIRWAY</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) <b>PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____                                                                                                                                                                                       |                                   |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                       |                                                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>SENILITY</b>                                                                                                                                                                                                  |                                   |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                       |                                                             |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                         |                                   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                                                                              | 20A. AUTOPSY? (Yes or No)                                                                             |                                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)                                                                                                                                                                                                                                                                     |                                   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                                                                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                              |                                                             |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                  |                                   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                                                                                                                                                                                              | 21F. HOW DID INJURY OCCUR?                                                                            |                                                             |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Oct 8</b> 19 <b>71</b> to <b>Nov 10</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>Nov 10</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                   |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                       |                                                             |
| 23A. SIGNATURE<br><b>Krant</b>                                                                                                                                                                                                                                                                                                                             |                                   |                                                                                                                                                             | 23B. DATE SIGNED<br><b>11-10-71</b>                                                                                                                                                                                                                                                                                                                          |                                                                                                       |                                                             |
| 23C. PHYSICIAN'S NAME (Type)<br><b>NAVAL KRANT, M.D.</b>                                                                                                                                                                                                                                                                                                   |                                   |                                                                                                                                                             | 23D. ADDRESS<br><b>S. Baltimore Gen. Hospital<br/>3001 S. Hanover St. Balt. Md.</b>                                                                                                                                                                                                                                                                          |                                                                                                       |                                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                  | 24B. DATE<br><b>Nov. 13, 1971</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Cemetery</b>                                                                                              |                                                                                                                                                                                                                                                                                                                                                              | 24D. LOCATION (City, town, or county) (State)<br><b>Woodlawn - Baltimore, Md.</b>                     |                                                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b>                                                                                                                                                                                                                                                                                                      |                                   | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>                                                                                                     |                                                                                                                                                                                                                                                                                                                                                              | 25C. FUNERAL DIRECTOR<br><b>CURTIS E. EVANS</b> ADDRESS<br><b>1400 S. Charles St. Baltimore 21230</b> |                                                             |



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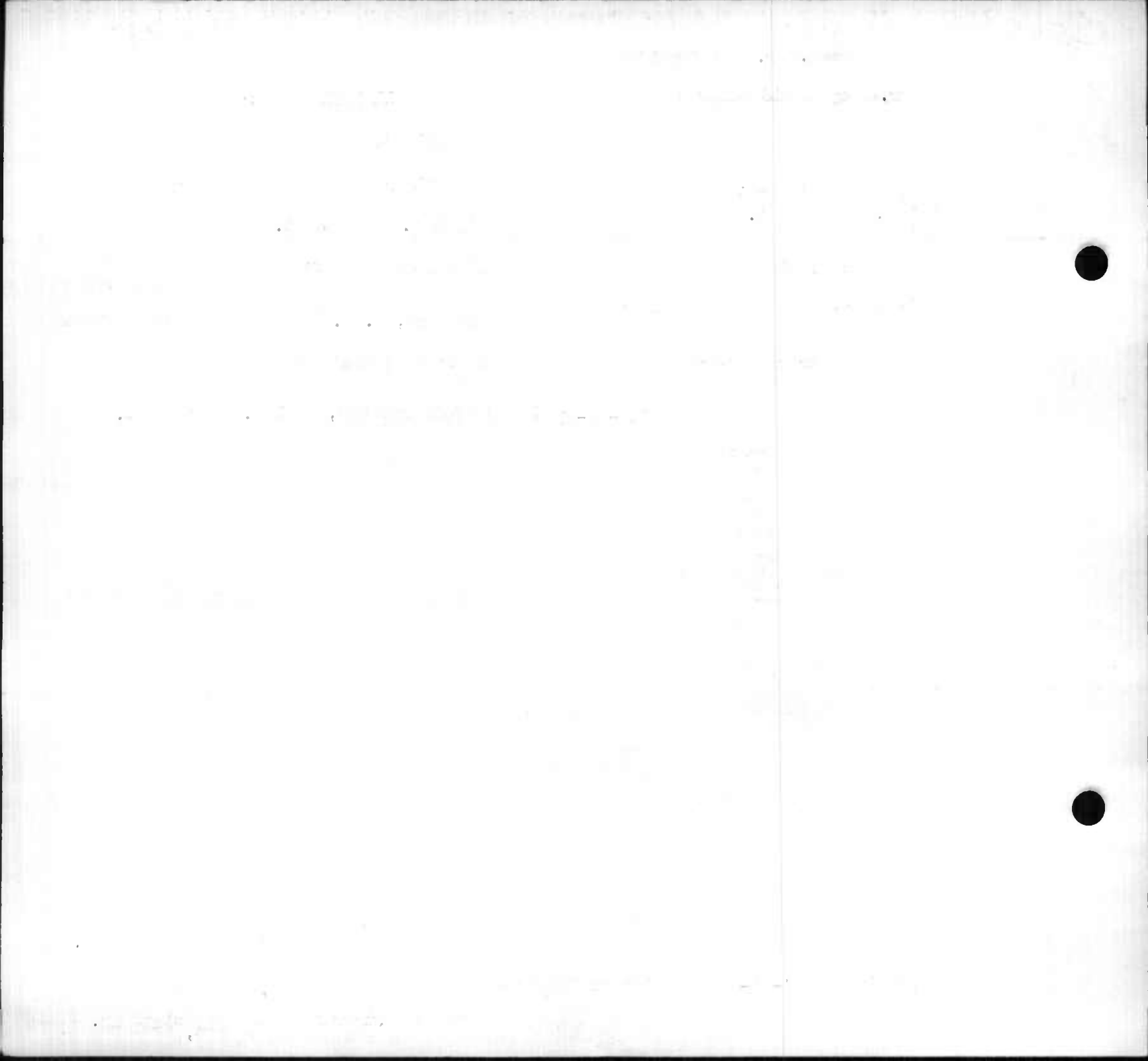
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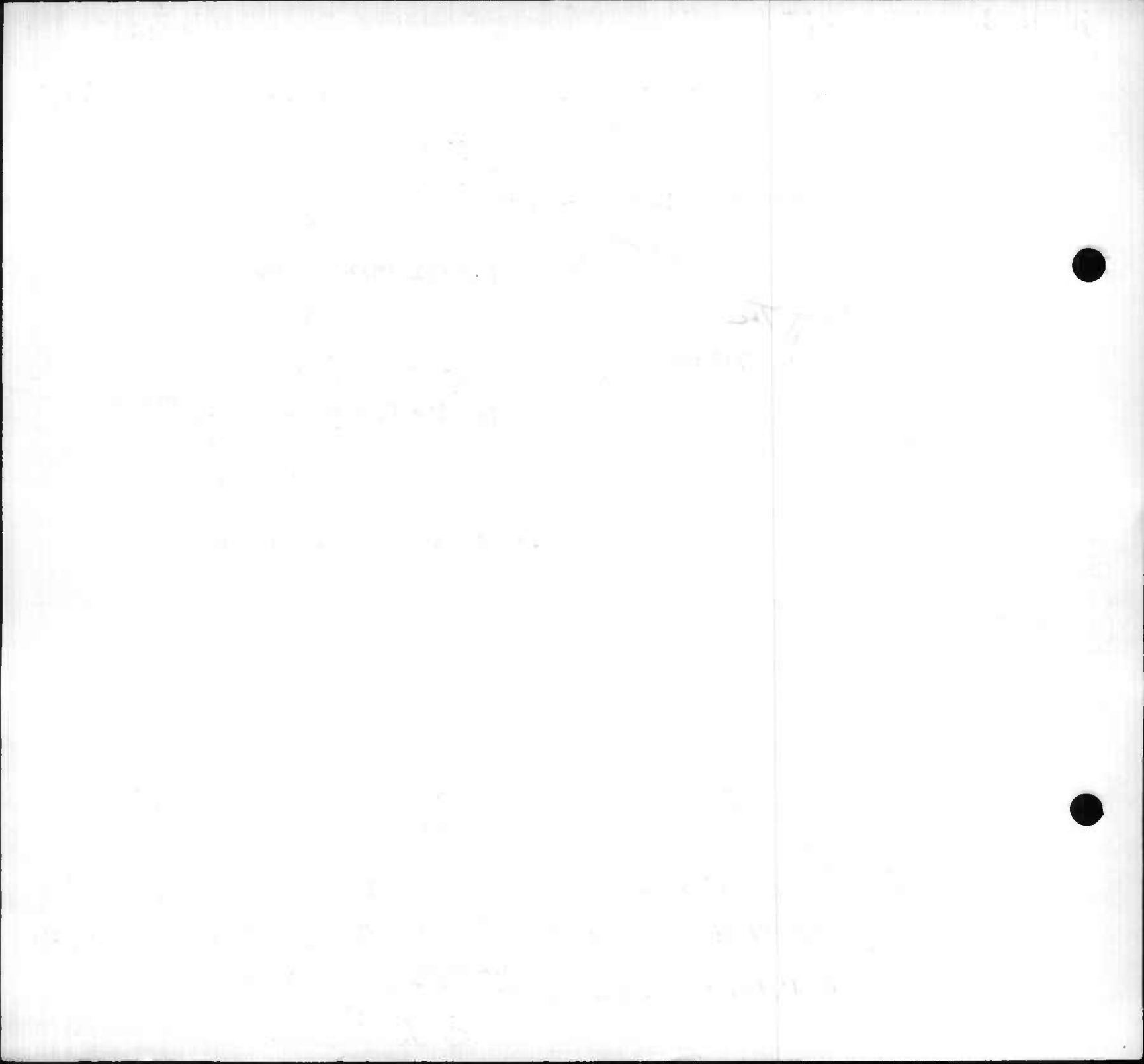
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                  |                             |                                                                                                                                                             |                                       | REG. NO. <b>71 10442</b>                                                                      |                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------|
| 71 10442                                                                                                                                                                                                                                                                                                                                                  |                             |                                                                                                                                                             |                                       |                                                                                               |                                          |
| BIRTH NO. C                                                                                                                                                                                                                                                                                                                                               |                             |                                                                                                                                                             |                                       |                                                                                               |                                          |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>N Sr. Mary David Cameron</b>                                                                                                                                                                                                                                                                                 |                             | 2. DATE AND HOUR OF DEATH<br><b>11/7/71 11:45 PM</b>                                                                                                        |                                       |                                                                                               |                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>N otre Dame of Maryland<br/>4701 N. Charles St.</b>                                                                                                                         |                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Ba ltimore</b><br>B. COUNTY <b>2711</b>                |                                       |                                                                                               |                                          |
|                                                                                                                                                                                                                                                                                                                                                           |                             | 5. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                         |                                       | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                          |
|                                                                                                                                                                                                                                                                                                                                                           |                             | E. STREET AND NUMBER<br><b>4701 N. Charles St.</b>                                                                                                          |                                       |                                                                                               |                                          |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                   | 6. RACE<br><b>caucasian</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11/27/1906</b> | 9. AGE (In years last birthday)<br><b>64</b>                                                  | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Librarian</b>                                                                                                                                                                                                                                           |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>                                                                                                       |                                       | 11. BIRTHPLACE (State or foreign country)<br><b>Yonkers, N. Y.</b>                            |                                          |
| 13. FATHER'S NAME<br><b>Thomas Patrick Cameron</b>                                                                                                                                                                                                                                                                                                        |                             | 14. MOTHER'S MAIDEN NAME<br><b>Ca therine MacDonald</b>                                                                                                     |                                       |                                                                                               |                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                  |                             | 16. SOCIAL SECURITY NO.<br><b>213-60-6706</b>                                                                                                               |                                       | 17. INFORMANT ADDRESS<br><b>Convent records, 4701 N. Charles St.</b>                          |                                          |
| 18. <b>203X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                             | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Myelenter</b>                                                                                  |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |                                          |
|                                                                                                                                                                                                                                                                                                                                                           |                             | (B) <b>Multiple myeloma</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                              |                                       |                                                                                               |                                          |
|                                                                                                                                                                                                                                                                                                                                                           |                             | (C) _____                                                                                                                                                   |                                       |                                                                                               |                                          |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                    |                             |                                                                                                                                                             |                                       |                                                                                               |                                          |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                        |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                       | 20A. AUTOPSY? (Yes or No)                                                                     |                                          |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                     |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                          |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                 |                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                       | 21F. HOW DID INJURY OCCUR?                                                                    |                                          |
| 22. I certify that (I) (this hospital) attended the deceased from <b>January 19 71</b> to <b>11/7/71</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>11/5/71</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                             |                                                                                                                                                             |                                       |                                                                                               |                                          |
| 23A. SIGNATURE<br><b>Chas E. Carr Jr MD</b>                                                                                                                                                                                                                                                                                                               |                             | 23B. DATE SIGNED<br><b>11/10/71</b>                                                                                                                         |                                       | 23C. PHYSICIAN'S NAME (Type)<br><b>CHAS. E. CARR JR MD</b>                                    |                                          |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                 |                             | 24B. DATE<br><b>11-10-71</b>                                                                                                                                |                                       | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Sisters Cemetery</b>                                 |                                          |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b>                                                                                                                                                                                                                                                                                                     |                             | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, MD</b>                                                                                                       |                                       | 25C. FUNERAL DIRECTOR<br><b>Raymond J. Curran</b>                                             |                                          |
|                                                                                                                                                                                                                                                                                                                                                           |                             | 24D. LOCATION (City, town, or county)<br><b>Baltimore, Maryland</b>                                                                                         |                                       | 24E. ADDRESS<br><b>817 Scarlett Dr. Towson, Maryland 21204</b>                                |                                          |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

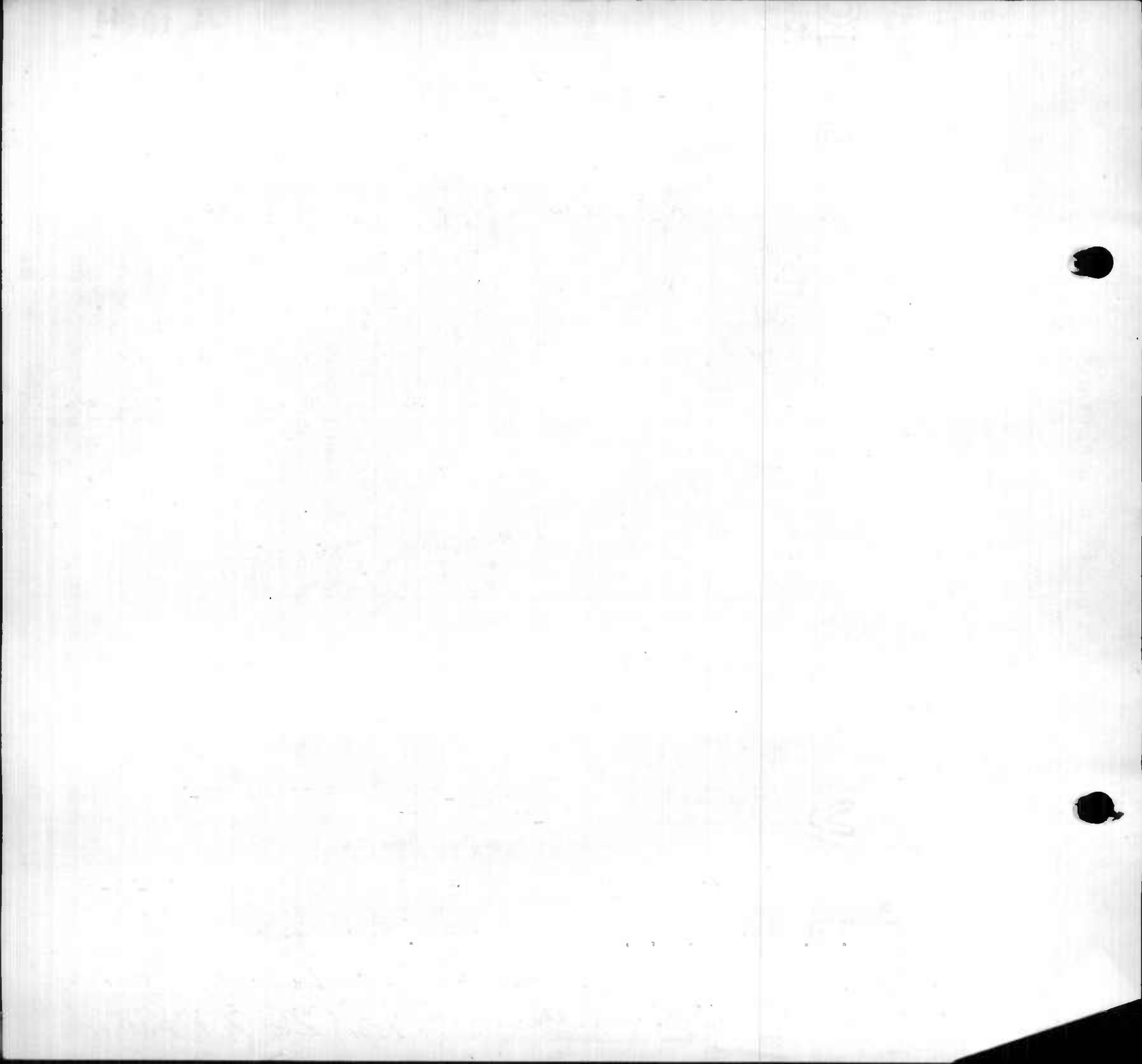
|                                                                                                                                                                                                                                                                                                                                      |                                                                                                                    |                                                                                                                                                                            |                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                      |                                                                                                                    | REG. NO. <b>71 10443</b>                                                                                                                                                   |                                   |
| BIRTH NO. <b>71 10443</b>                                                                                                                                                                                                                                                                                                            |                                                                                                                    | 2. DATE AND HOUR OF DEATH<br><b>11-10-71 3:00 p.m.</b>                                                                                                                     |                                   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Ernest Malloy</b>                                                                                                                                                                                                                                                                          |                                                                                                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>md</b> B. COUNTY <b>1303</b>                                          |                                   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>90 Lincoln Nursing Home</b>                                                                                                                            |                                                                                                                    | C. CITY OR TOWN <b>Balti</b> D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                            |                                   |
| E. STREET AND NUMBER<br><b>2422 madison ave</b>                                                                                                                                                                                                                                                                                      |                                                                                                                    | 6. DATE OF BIRTH <b>Feb 12 1912</b> 9. AGE (In years last birthday) <b>59</b>                                                                                              |                                   |
| 5. SEX <b>M</b> 6. RACE <b>Cul N</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                     | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Limboing Tee</b> |                                                                                                                                                                            | 10B. KIND OF BUSINESS OR INDUSTRY |
| 13. FATHER'S NAME<br><b>prince A malloy</b>                                                                                                                                                                                                                                                                                          |                                                                                                                    | 14. MOTHER'S MAIDEN NAME<br><b>Effie Hill</b>                                                                                                                              |                                   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                             |                                                                                                                    | 16. SOCIAL SECURITY NO.                                                                                                                                                    |                                   |
| 17. INFORMANT<br><b>mis DOTSEY MALLOY</b>                                                                                                                                                                                                                                                                                            |                                                                                                                    | ADDRESS<br><b>2422 madison ave</b>                                                                                                                                         |                                   |
| 18. <b>571.9 I</b> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                    |                                                                                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                               |                                   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                                                                                                                    | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Hepatic Coma</b><br><br>(B) <b>Cirrhosis of the liver</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |                                   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                     |                                                                                                                    |                                                                                                                                                                            |                                   |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                   |                                                                                                                    | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                           |                                   |
| 20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                |                                                                                                                    | 20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                   |                                   |
| 21A. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                             |                                                                                                                    | 21B. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                  |                                   |
| 21C. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                               |                                                                                                                    | 21D. HOW DID INJURY OCCUR?                                                                                                                                                 |                                   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9-24-1971</b> to <b>11-10-1971</b> that (I) (we) last saw the deceased alive on <b>11-9-1971</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.          |                                                                                                                    |                                                                                                                                                                            |                                   |
| 23A. SIGNATURE<br><b>A. I. Baykaler</b>                                                                                                                                                                                                                                                                                              |                                                                                                                    | 23B. DATE SIGNED<br><b>11-10-71</b>                                                                                                                                        |                                   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>A. I. BAYKALER, M.D.</b>                                                                                                                                                                                                                                                                          |                                                                                                                    | 23D. ADDRESS<br><b>301 Mc Mechen St. Baltimore, md</b>                                                                                                                     |                                   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>B</b>                                                                                                                                                                                                                                                                                 |                                                                                                                    | 24B. DATE<br><b>11/14/71</b>                                                                                                                                               |                                   |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Grove Burying</b>                                                                                                                                                                                                                                                                     |                                                                                                                    | 24D. LOCATION (City, town, or county) (State)<br><b>NC</b>                                                                                                                 |                                   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b>                                                                                                                                                                                                                                                                                |                                                                                                                    | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, R.D.</b>                                                                                                                    |                                   |
| 25C. FUNERAL DIRECTOR<br><b>J. L. Brown</b>                                                                                                                                                                                                                                                                                          |                                                                                                                    | ADDRESS                                                                                                                                                                    |                                   |



FUNERAL DIRECTOR: IMPORTANT

Certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased as D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

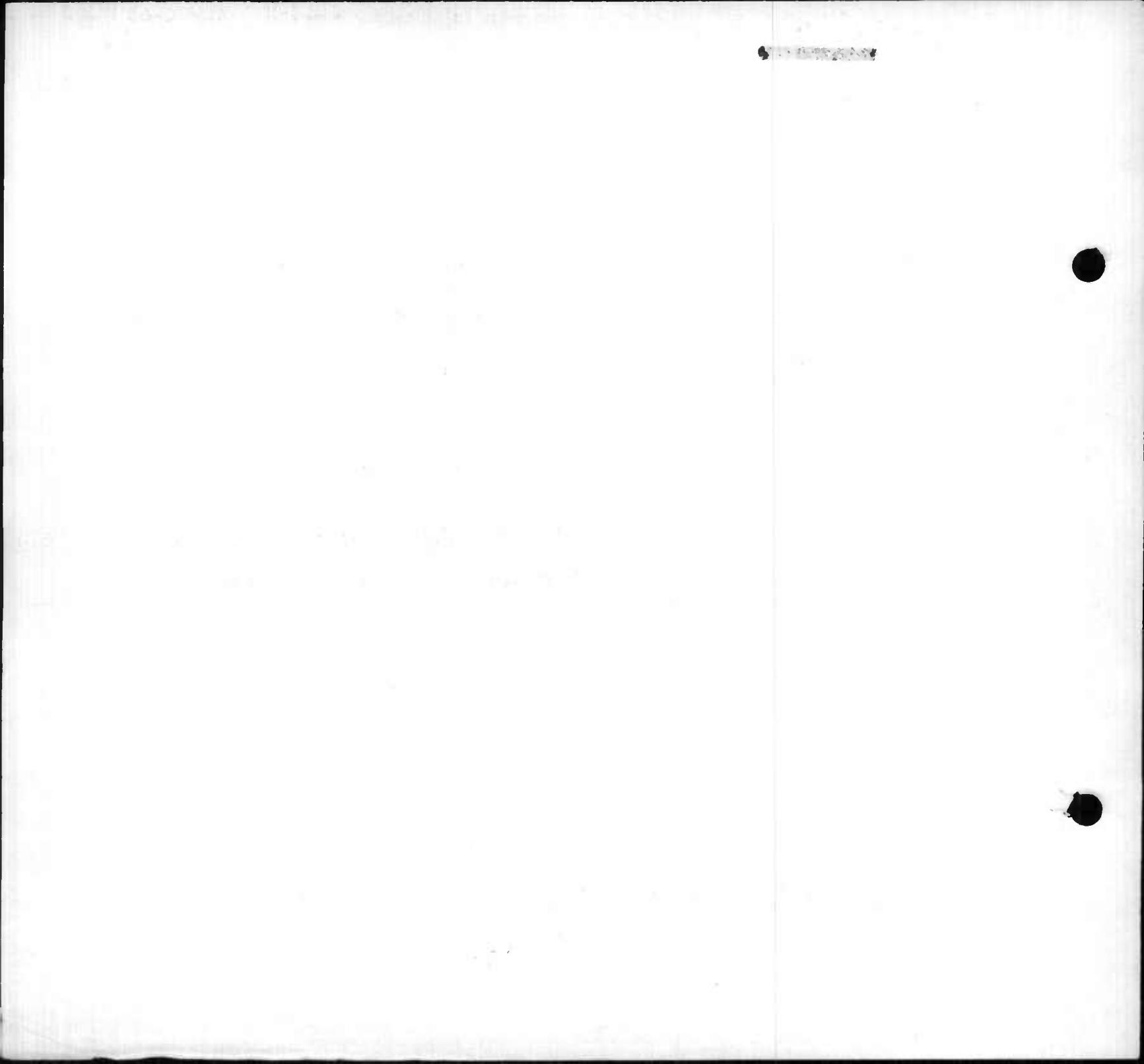
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                            |  | REG. NO. <span style="font-size: 1.5em;">71 10444</span>                                                                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 71 10444                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                            |  | CERTIFICATE OF DEATH                                                                                                                                        |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                 |  | 1. NAME OF DECEASED<br>(Type or Print) <i>James F Majewski (Majewski)</i>                                                                  |  |                                                                                                                                                             |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                    |  | 2. DATE AND HOUR OF DEATH<br><i>November 9, 1971 7:30 A. M.</i>                                                                            |  |                                                                                                                                                             |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>00 1313 Cooksie ST. Baltimore, Md. 21230</i>                                                                                                                                                                                                                                                                   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i><br>B. COUNTY <i>2401</i> |  | C. CITY OR TOWN <i>Baltimore</i>                                                                                                                            |  |
| 5. SEX <i>M</i>                                                                                                                                                                                                                                                                                                                                           |  | 6. RACE <i>W</i>                                                                                                                           |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Longshoreman</i>                                                                                                                                                                                                                                        |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>—                                                                                                     |  | 9. AGE (In years lost birthday) <i>75</i>                                                                                                                   |  |
| 13. FATHER'S NAME<br><i>Stanley Majewski</i>                                                                                                                                                                                                                                                                                                              |  | 14. MOTHER'S MAIDEN NAME<br><i>Frances Bubczyk</i>                                                                                         |  | 11. BIRTHPLACE (State or foreign country)<br><i>Poland</i>                                                                                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>Yes World War I</i>                                                                                                                                                                                                                        |  | 16. SOCIAL SECURITY NO.<br><i>215-09-3219</i>                                                                                              |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>                                                                                                             |  |
| 17. INFORMANT<br><i>Mrs. Frances Majewski</i>                                                                                                                                                                                                                                                                                                             |  | ADDRESS<br><i>1313 Cooksie ST.</i>                                                                                                         |  | 18. <i>412.4 I</i>                                                                                                                                          |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                            |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>Myocardial Failure - Sudden</i>                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>10 yrs +</i>                                                                                             |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                            |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><i>Arteriosclerotic Cardiovascular Disease</i>                                                      |  | (C) <i>none</i>                                                                                                                                             |  |
| II                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                            |  |                                                                                                                                                             |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                                                             |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                    |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                 |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                     |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5-26</i> 19 <i>55</i> to <i>10-11</i> 19 <i>71</i> , that (I) (we) last saw the deceased alive on <i>10-11</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                            |  |                                                                                                                                                             |  |
| 23A. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                            |  | 23B. DATE SIGNED<br><i>11-11-71</i>                                                                                                                         |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>E. S. Ellison, M.D.</i>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                            |  | 23D. ADDRESS<br><i>107 E. West Street</i>                                                                                                                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                 |  | 24B. DATE<br><i>11/13/71</i>                                                                                                               |  | 24C. NAME OF CEMETERY or CREMATORY<br><i>Maryland National Memorial Park</i>                                                                                |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Laurel, Maryland</i>                                                                                                                                                                                                                                                                                  |  | 25A. DATE REC'D BY HEALTH DEPT.<br><i>NOV 12 1971</i>                                                                                      |  |                                                                                                                                                             |  |
| 25B. NAME OF REGISTRAR<br><i>Robert E. Garber, M.D.</i>                                                                                                                                                                                                                                                                                                   |  | 25C. FUNERAL DIRECTOR<br><i>Charles L. Stevens Funeral Home, Inc.</i>                                                                      |  |                                                                                                                                                             |  |
| ADDRESS<br><i>1501 East Fort Avenue</i>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                            |  |                                                                                                                                                             |  |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                                                                                                                                                                                                           |                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                        |                  | JEAN-M 42-70-63<br>REG. NO. <b>71 10445</b>                                                                                                                                                                                                                                                                                               |                                                                                                                        |
| BIRTH NO. <b>W-42511-18444</b> <b>10445</b>                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                                                                                                                                                                                                           |                                                                                                                        |
| 1. NAME OF DECEASED<br>(Type as Print) <b>Barry Girth Wilson</b>                                                                                                                                                                                                                                                                                       |                  | 2. DATE AND HOUR OF DEATH<br><b>11/1/71</b> <b>2 50 P.M.</b>                                                                                                                                                                                                                                                                              |                                                                                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>University of Maryland Hosp.</b><br><b>38</b>                                                                                                                            |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore City</b><br>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER<br><b>500 Bridgeview Road</b> |                                                                                                                        |
| 5. SEX <b>F</b>                                                                                                                                                                                                                                                                                                                                        | 6. RACE <b>B</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                          | 8. DATE OF BIRTH <b>11/1/71</b>                                                                                        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                            |                  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                         | 9. AGE (In years last birthday) <b>0</b><br>If Under 1 Yr. Months <b>0</b> Days <b>0</b> Hours <b>7</b> Min. <b>50</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                           |                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                |                                                                                                                        |
| 13. FATHER'S NAME<br><b>Charles Wilson</b>                                                                                                                                                                                                                                                                                                             |                  | 14. MOTHER'S MAIDEN NAME<br><b>Jean</b>                                                                                                                                                                                                                                                                                                   |                                                                                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                               |                  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                   | 17. INFORMANT ADDRESS                                                                                                  |
| 18. <b>776.2 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>RESP. FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>RESP. DISTRESS SYND. INTRACRANIAL HEM</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>PREMATURITY - 25WK GEST</b>                                                                                                                |                                                                                                                        |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                 |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                              |                                                                                                                        |
| 19A. DATE OF OPERATION <b>2</b>                                                                                                                                                                                                                                                                                                                        |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                          | 20A. AUTOPSY? (Yes or No) <b>YES</b>                                                                                   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                                                                                                                                                                                                           |                                                                                                                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examiner examined)                                                                                                                                                                                                                                                             |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                               |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                              |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                 | 21F. HOW DID INJURY OCCUR?                                                                                             |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/31</b> 19 <b>71</b> to <b>11/1</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>11/1</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |                                                                                                                                                                                                                                                                                                                                           |                                                                                                                        |
| 23A. SIGNATURE<br><b>Stephen Dubausch</b>                                                                                                                                                                                                                                                                                                              |                  | 23B. DATE SIGNED<br><b>11/1/71</b>                                                                                                                                                                                                                                                                                                        | 23C. PHYSICIAN'S NAME (Type)<br><b>Stephen Dubausch, M.D.</b>                                                          |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                               |                  | 24B. DATE<br><b>11-8-71</b>                                                                                                                                                                                                                                                                                                               | 24C. NAME OF CEMETERY or CREMATORY<br><b>ANATOMY BOARD OF MARYLAND</b>                                                 |
| 24D. LOCATION (City, town or county)                                                                                                                                                                                                                                                                                                                   |                  | 24E. LOCATION (State)                                                                                                                                                                                                                                                                                                                     |                                                                                                                        |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b>                                                                                                                                                                                                                                                                                                  |                  | 25B. NAME OF REGISTRAR<br><b>Robert E. Garber, M.D.</b>                                                                                                                                                                                                                                                                                   | 25C. FUNERAL DIRECTOR<br><b>MORTUARY SERVICE - BCD</b>                                                                 |

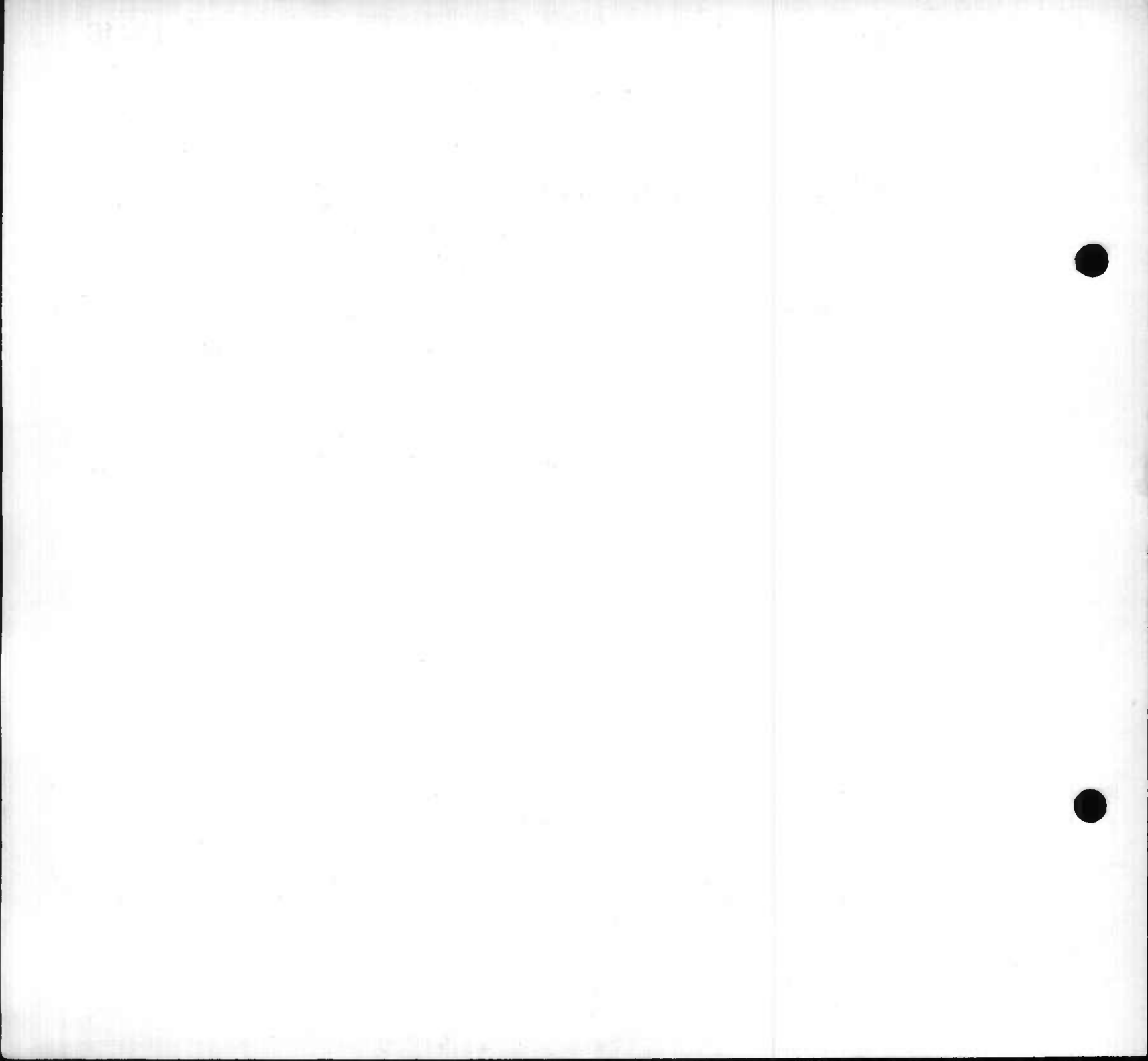




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

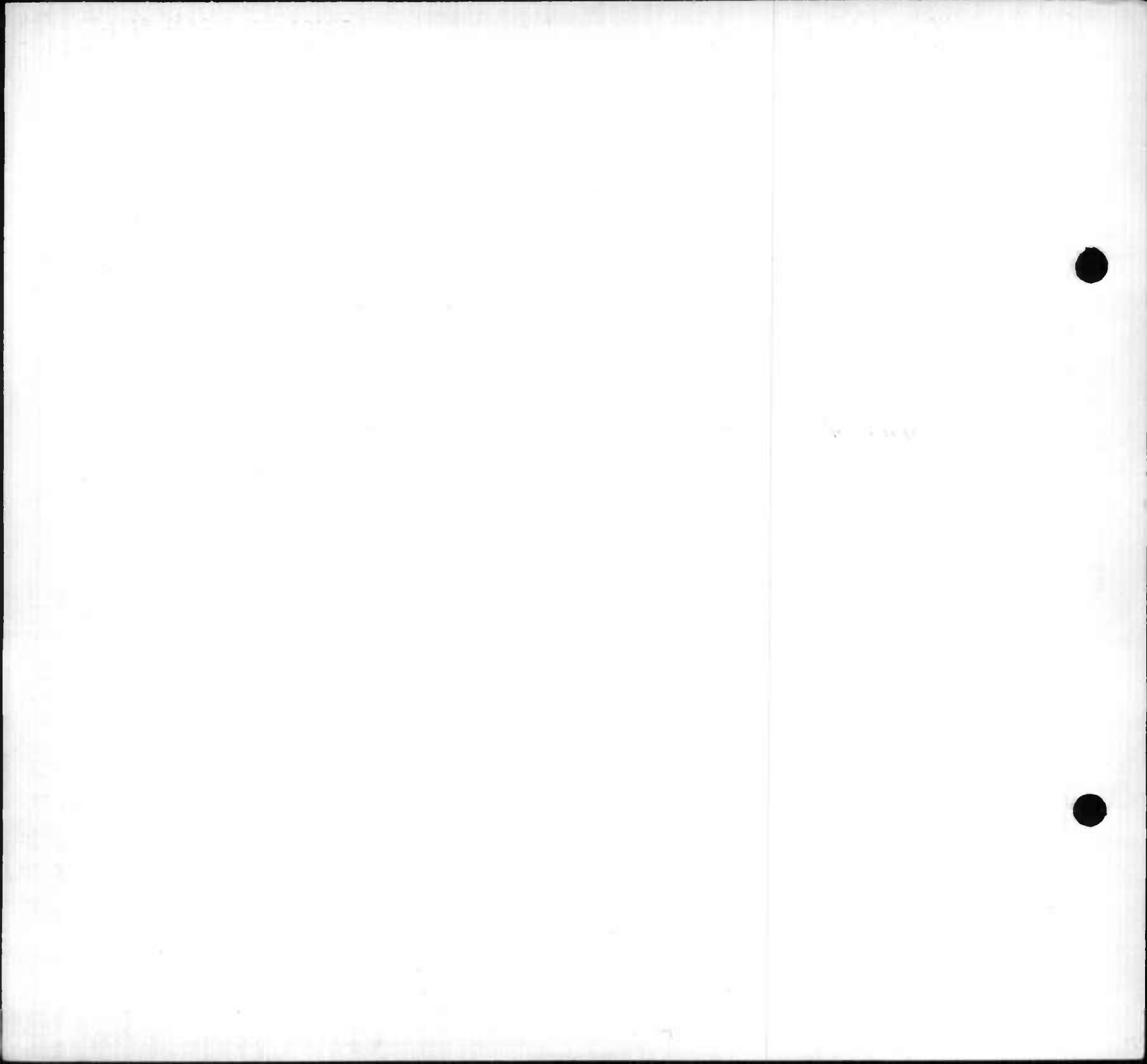
| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                |  |                                                                           |  | REG. NO. <b>71 10446</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>C-365</b><br><b>BIRTH NO. 71-19807 10446</b>                                                                                                                                                                         |  | <b>1. NAME OF DECEASED</b><br>(Type or Print) <b>CAUTHORNE, BABY GIRL</b> |  |                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location)<br><b>U. of Maryland Hospital</b> |  | <b>2. DATE AND HOUR OF DEATH</b><br><b>10/28/71 12:15 A.M.</b>            |  |                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| <b>5. SEX</b><br><b>F</b>                                                                                                                                                                                               |  | <b>6. RACE</b><br><b>N</b>                                                |  | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>                                                                                                                                                                                                                                      |  |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>infant</b>                                                                                                     |  | <b>10B. KIND OF BUSINESS OR INDUSTRY</b>                                  |  | <b>8. DATE OF BIRTH</b><br><b>27/10/71</b>                                                                                                                                                                                                                                                                                                                                                                        |  |
| <b>13. FATHER'S NAME</b>                                                                                                                                                                                                |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Mary Ann Cauthorne</b>              |  | <b>9. AGE (in years last birthday)</b><br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>                                                                                         |  | <b>16. SOCIAL SECURITY NO.</b>                                            |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Baltimore Md</b>                                                                                                                                                                                                                                                                                                                                           |  |
| <b>17. INFORMANT</b><br><b>Chart</b>                                                                                                                                                                                    |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>                      |  | <b>18. CAUSE OF DEATH</b><br><b>777X I</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>immaturity</b><br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |
| <b>19. DATE OF OPERATION</b><br><b>0</b>                                                                                                                                                                                |  |                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| <b>20. AUTOPSY?</b> (Yes or No)<br><b>no</b>                                                                                                                                                                            |  |                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| <b>21. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                          |  |                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>27/10</b> <b>1971</b> <b>to</b> <b>28/10</b> <b>1971</b>                                                                                    |  |                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| <b>23. SIGNATURE</b><br><b>John V. Payne M.D.</b>                                                                                                                                                                       |  |                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| <b>24. BURIAL CREMATION, REMOVAL (Specify)</b><br><b>11-8-71</b>                                                                                                                                                        |  |                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| <b>25. DATE REC'D BY HEALTH DEPT.</b><br><b>NOV 12 1971</b>                                                                                                                                                             |  |                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| <b>26. NAME OF REGISTRAR</b><br><b>Robert E. Fisher, M.D.</b>                                                                                                                                                           |  |                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| <b>27. FUNERAL DIRECTOR</b><br><b>MORTUARY SERVICE - BCHD</b>                                                                                                                                                           |  |                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| <b>28. ADDRESS</b><br><b>ANATOMY BOARD OF MARYLAND</b><br><b>UNIVERSITY MEDICAL SCHOOL</b>                                                                                                                              |  |                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

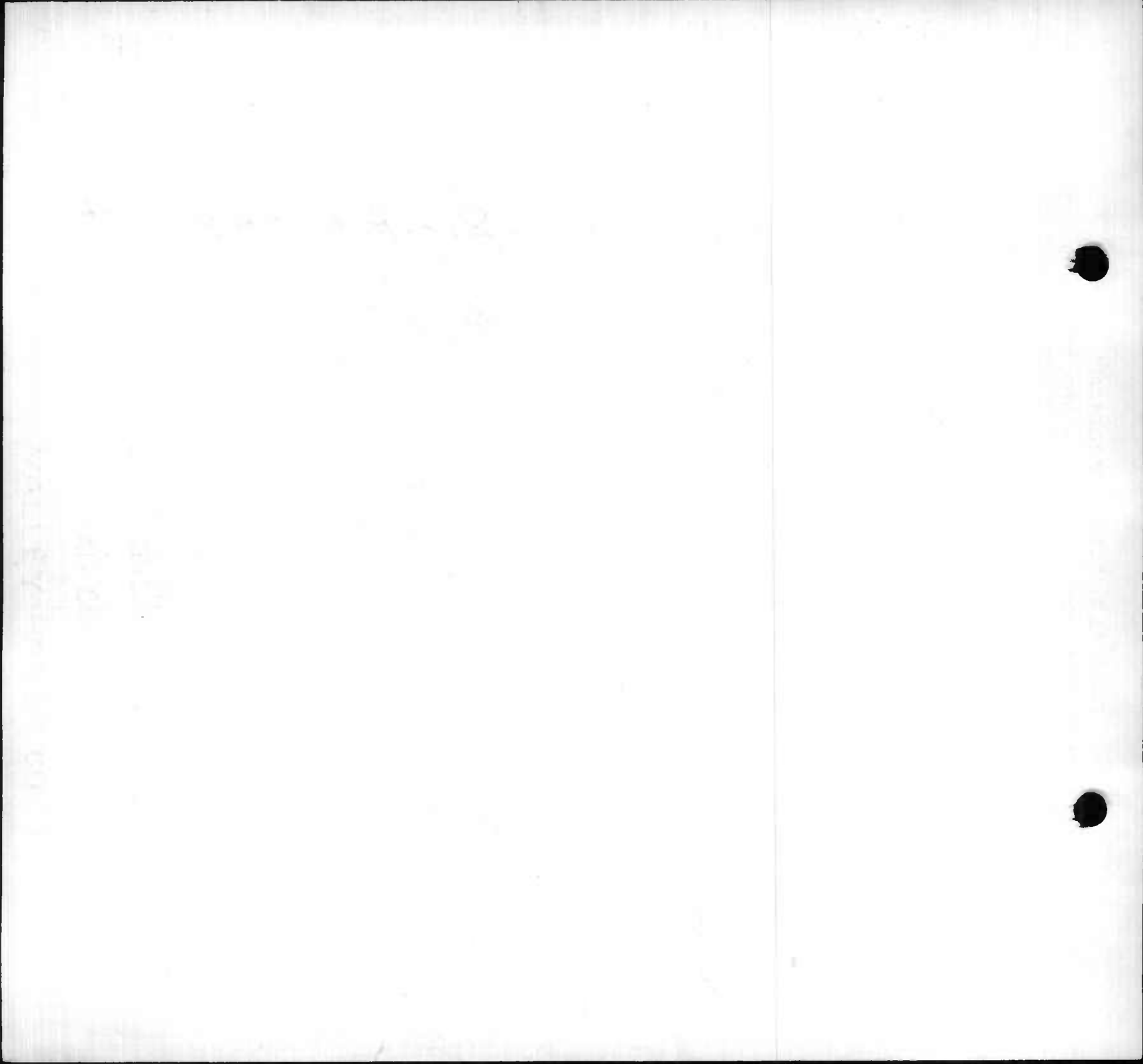
|                                                                                                                                                                                                                                                                                                                                                        |                     |                                                                                                                                                                          |                                     |                                                                          |                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------|--------------------------------------------|
| B-620 71 10447<br>21-17431                                                                                                                                                                                                                                                                                                                             |                     | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                 |                                     | BRACY, BABY GIRL 10447<br>REG. NO. 10447<br>FLOISE X 42-71-20            |                                            |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                              |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>BABY GIRL BRACY</b>                                                                                                            |                                     | 2. DATE AND HOUR OF DEATH<br><b>10/19/71 16:50 A.M.</b>                  |                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                 |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>                             |                                     | C. CITY OR TOWN <b>BALTIMORE</b>                                         |                                            |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNIVERSITY OF MARYLAND HOSPITAL</b>                                                                                                                                                                                                                                                                         |                     | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                            |                                     | E. STREET AND NUMBER<br><b>508 N. SCHROEDER STREET</b>                   |                                            |
| 5. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                     | 6. RACE<br><b>N</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>              | 8. DATE OF BIRTH<br><b>10/18/71</b> | 9. AGE (In years last birthday)                                          | If Under 1 Yr. Months Days<br><b>13 35</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NEWBORN</b>                                                                                                                                                                                                                                          |                     | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                        |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>             |                                            |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                      |                     | 14. MOTHER'S MAIDEN NAME<br><b>FLOISE BRACY</b>                                                                                                                          |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                            |                                            |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                  |                     | 16. SOCIAL SECURITY NO.                                                                                                                                                  |                                     | 17. INFORMANT ADDRESS                                                    |                                            |
| 18. <b>776.2 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>RESPIRATORY DISTRESS</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>PREMATURITY</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>13 hrs</b>            |                                            |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                 |                     |                                                                                                                                                                          |                                     |                                                                          |                                            |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                 |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                         |                                     | 20A. AUTOPSY? (Yes or No)                                                |                                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner)                                                                                                                                                                                                                                                                 |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                 |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                            |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                              |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                   |                                     | 21F. HOW DID INJURY OCCUR?                                               |                                            |
| 22. I certify that (I) (this hospital) attended the deceased from <b>19 October 1971</b> to <b>19 October 1971</b> that (I) (we) last saw the deceased alive on <b>19 October 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.        |                     |                                                                                                                                                                          |                                     |                                                                          |                                            |
| 23A. SIGNATURE<br><b>Joan M. Reese, M.D.</b>                                                                                                                                                                                                                                                                                                           |                     | 23B. DATE SIGNED<br><b>10/19/71</b>                                                                                                                                      |                                     | 23C. PHYSICIAN'S NAME (Type)<br><b>JOAN M. REESE, M.D.</b>               |                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                               |                     | 24B. DATE<br><b>11-8-71</b>                                                                                                                                              |                                     | 24C. NAME OF CEMETERY OR CREMATORY<br><b>ANATOMY BOARD OF MARYLAND</b>   |                                            |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b>                                                                                                                                                                                                                                                                                                  |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Faber, M.D.</b>                                                                                                                   |                                     | 25C. FUNERAL DIRECTOR<br><b>UNIVERSITY MEDICAL SCHOOL</b>                |                                            |
| 25D. LOCATION<br><b>BALTIMORE, MARYLAND</b>                                                                                                                                                                                                                                                                                                            |                     | 25E. CITY, TOWN, OR COUNTY<br><b>BALTIMORE</b>                                                                                                                           |                                     | 25F. STATE<br><b>MARYLAND</b>                                            |                                            |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                              |  |                                                                                       |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|
| <b>D-400</b> <b>71</b> <b>10448</b>                                                                                                                                                                                                                                                                                                                                         |  | <b>BALTIMORE CITY HEALTH DEPARTMENT</b><br><b>CERTIFICATE OF DEATH</b>                                                                                                       |  | <b>REG. NO.</b> <b>71</b> <b>10448</b>                                                |  |
| <b>BIRTH NO.</b> <b>71-17559</b>                                                                                                                                                                                                                                                                                                                                            |  | <b>1. NAME OF DECEASED</b><br>(Type or Print) <b>Baby Boy Dailey</b>                                                                                                         |  |                                                                                       |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>                                                                                                                                                                                                                                                                                                               |  | <b>2. DATE AND HOUR OF DEATH</b><br><b>10-20-71 @ 8:15 PM.</b>                                                                                                               |  |                                                                                       |  |
| <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Lutheran Hospital of Maryland</b>                                                                                                                                                                                                                    |  | <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br><b>A. STATE</b> <b>B. COUNTY</b>                                             |  | <b>1608</b>                                                                           |  |
| <b>5. SEX</b> <b>M</b> <b>6. RACE</b> <b>N</b>                                                                                                                                                                                                                                                                                                                              |  | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b> <b>10-20-71</b>                                               |  |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                          |  | <b>10B. KIND OF BUSINESS OR INDUSTRY</b>                                                                                                                                     |  | <b>9. AGE</b> (In years last birthday) <b>2</b>                                       |  |
| <b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore</b>                                                                                                                                                                                                                                                                                                           |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>                                                                                                                              |  | <b>13. FATHER'S NAME</b> <b>ADAMS JACK</b>                                            |  |
| <b>14. MOTHER'S MAIDEN NAME</b> <b>NANCY DAILEY</b>                                                                                                                                                                                                                                                                                                                         |  | <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>                                                    |  | <b>16. SOCIAL SECURITY NO.</b>                                                        |  |
| <b>17. INFORMANT</b>                                                                                                                                                                                                                                                                                                                                                        |  | <b>ADDRESS</b>                                                                                                                                                               |  |                                                                                       |  |
| <b>18. CAUSE OF DEATH</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | <b>(A) IMMEDIATE CAUSE</b><br><b>PREMATURE</b><br><b>EDC of Mother 28 Jan 72</b>                                                                                             |  | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>                                   |  |
| <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>about 26 weeks gestation</b>                                                                                                                                                                                                                                                                                               |  | <b>(C)</b>                                                                                                                                                                   |  |                                                                                       |  |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>                                                                                                                                                                                                                        |  |                                                                                                                                                                              |  |                                                                                       |  |
| <b>19A. DATE OF OPERATION</b>                                                                                                                                                                                                                                                                                                                                               |  | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>                                                                                                                      |  | <b>20A. AUTOPSY? (Yes or No)</b>                                                      |  |
| <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                              |  |                                                                                       |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)                                                                                                                                                                                                                                                                                |  | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                               |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)       |  |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                            |  | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                             |  | <b>21F. HOW DID INJURY OCCUR?</b>                                                     |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>10-20-71</b> <b>19</b> <b>to</b> <b>10-20-71</b> <b>19</b><br>that (I) (we) last saw the deceased alive on <b>10-20-71</b> <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |                                                                                                                                                                              |  |                                                                                       |  |
| <b>23A. SIGNATURE</b><br><b>ABDUL MAJID MEMAN</b>                                                                                                                                                                                                                                                                                                                           |  | <b>23B. DATE SIGNED</b>                                                                                                                                                      |  |                                                                                       |  |
| <b>23C. PHYSICIAN'S NAME</b> (Type)                                                                                                                                                                                                                                                                                                                                         |  | <b>23D. ADDRESS</b><br><b>730 Ashburton St. Lutheran Hospital Balto Mo</b>                                                                                                   |  |                                                                                       |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b>                                                                                                                                                                                                                                                                                                                             |  | <b>24B. DATE</b> <b>11-11-71</b>                                                                                                                                             |  | <b>24C. NAME OF CEMETERY or CREMATORY</b> <b>ANATOMY BOARD OF MARYLAND</b>            |  |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>NOV 12 1971</b>                                                                                                                                                                                                                                                                                                                   |  | <b>25B. NAME OF REGISTRAR</b> <b>Blaise Taylor, M.D.</b>                                                                                                                     |  | <b>25C. FUNERAL DIRECTOR</b> <b>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCDD</b> |  |



M-300 71

10449

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 10449

BIRTH NO.

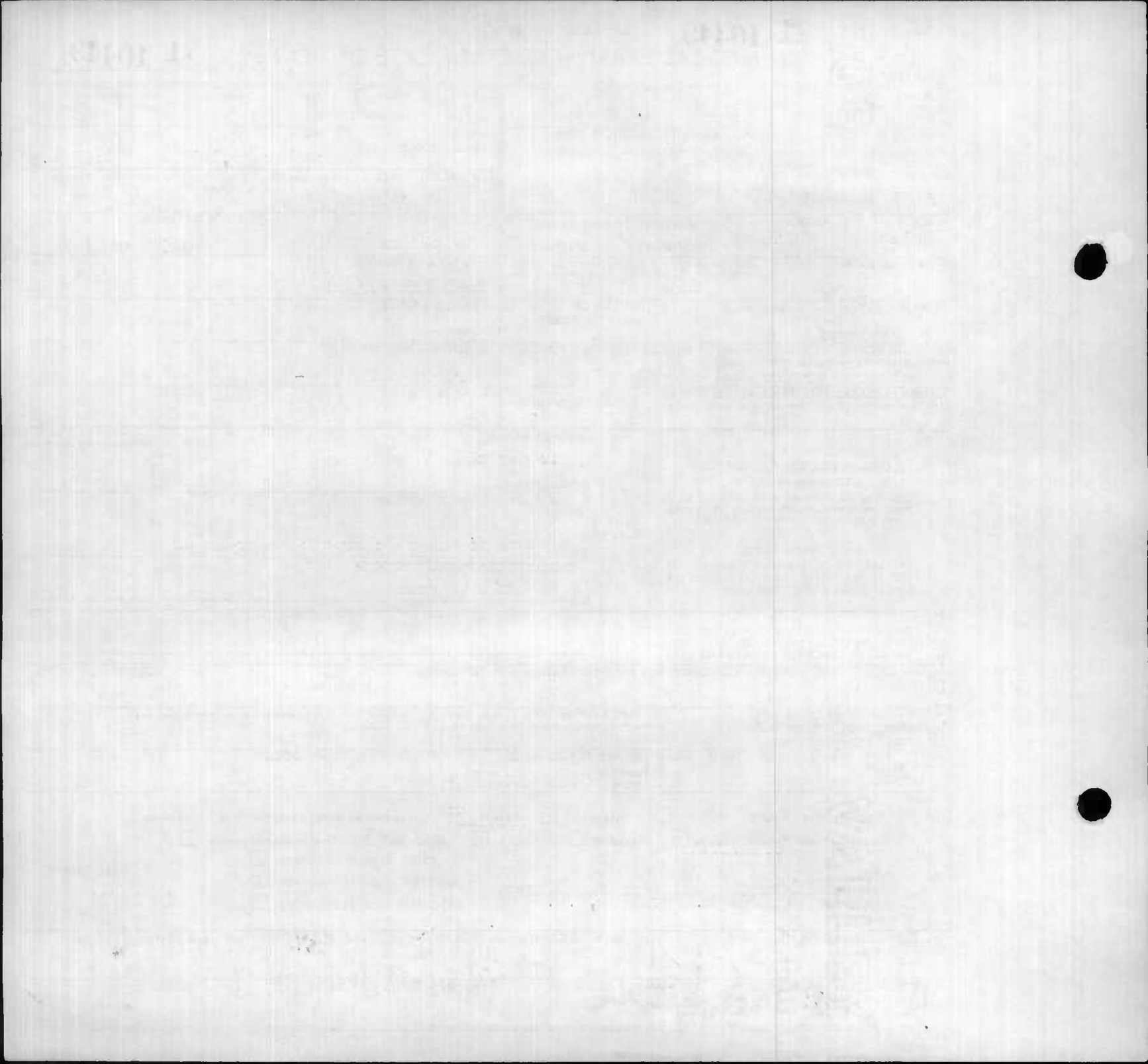
|                                                                                                                                                  |  |                                                                                                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>WILLIAM F. MEAD</b>                                                                                    |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> Hour M.                         |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>44 UNION MEMORIAL HOSPITAL</b>              |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>October 19, 1971 4:40 P.M.</b>                                                     |  |
| 6. SEX<br><b>Male</b>                                                                                                                            |  | 7. RACE<br><b>White</b>                                                                                                                 |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1348</b> |  |
| 9. DATE OF BIRTH<br><b>Feb 4 1906</b>                                                                                                            |  | 10. AGE (In years lost birthday) <b>65</b>                                                                                              |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>                                                                                 |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                              |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machine Operator</b>                           |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Rug Cleaning</b>                                                                                |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes WW II</b>                      |  | 17. SOCIAL SECURITY NO.<br><b>213 38 8624</b>                                                                                           |  |
| 13. FATHER'S NAME<br><b>Unknown</b>                                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br><b>Barbara Ellen</b>                                                                                        |  |
| 18. INFORMANT                                                                                                                                    |  | ADDRESS                                                                                                                                 |  |

|                                                                                                                                        |                                                                                                                                                                                                                                                                               |  |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| MEDICAL CERTIFICATION                                                                                                                  | 19. <b>441.21</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br><b>Retroperitoneal Hematoma</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|                                                                                                                                        | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Rupture of Atherosclerotic Aneurysm of</b>                                                                                                                                                                       |  |                                              |
|                                                                                                                                        | (B) <del>THE TO OR AS A CONSEQUENCE OF</del>                                                                                                                                                                                                                                  |  |                                              |
|                                                                                                                                        | (C) <b>Abdominal Aorta</b>                                                                                                                                                                                                                                                    |  |                                              |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                                                                                                                                                                                                                                                                               |  |                                              |

|                                                                                                                      |  |                                                                                                           |  |                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| 20A. DATE OF OPERATION                                                                                               |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 21. AUTOPSY? (Yes or No)<br><b>yes</b>                                   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)                                                            |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 22F. HOW DID INJURY OCCUR?                                               |  |

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                |  |                                |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|--------------------------------|--|
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                |  |                                |  |
| ACTUAL SIGNATURE<br><b>Ronald N. Kornblum, M.D.</b>                                                                                                                                                                                                                                                                                                                                                           |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                |  | DATE SIGNED<br><b>10/20/71</b> |  |
| EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                        |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                               |  | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>            |  |                                |  |

|                                                       |  |                                                        |  |                                                                        |  |
|-------------------------------------------------------|--|--------------------------------------------------------|--|------------------------------------------------------------------------|--|
| 24A. BURIAL CREMATION, REMOVAL (Specify)              |  | 24B. DATE<br><b>11-8-71</b>                            |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>ANATOMY BOARD OF MARYLAND</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b> |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Gabel, M.D.</b> |  | 25C. FUNERAL DIRECTOR<br><b>UNIVERSITY MEDICAL SCHOOL</b>              |  |
|                                                       |  |                                                        |  | 25D. ADDRESS<br><b>MORTUARY SERVICE - BCHD</b>                         |  |





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

|                                                                                                                                                                                                         |  |                                                                                                                                                  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>EDWARD PETERSON</b>                                                                                                                                           |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.                                       |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 1326 Hollins Street</b> |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>October 6, 1971 8:30 P. M.</b>                                                              |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                   |  | 8. MARried <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7. RACE<br><b>White</b>                                                                                                                                                                                 |  | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1902</b>          |  |
| 9. DATE OF BIRTH                                                                                                                                                                                        |  | 10. AGE (In years lost birthday)<br><b>73</b>                                                                                                    |  |
| 11. BIRTHPLACE (State or foreign country)                                                                                                                                                               |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                     |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                             |  | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                 |  | 17. SOCIAL SECURITY NO.                                                                                                                          |  |
| 18. INFORMANT                                                                                                                                                                                           |  | ADDRESS                                                                                                                                          |  |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 19. <b>412.4</b><br>CAUSE OF DEATH<br><b>Arteriosclerotic cardiovascular disease</b><br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)<br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                              |
| (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                              |
| (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                              |

|                                                                                                                      |  |                                                                                                        |  |                                                                          |
|----------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|
| 20A. DATE OF OPERATION                                                                                               |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 21. AUTOPSY? (Yes or No)<br><b>No</b>                                    |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)                                                            |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 22F. HOW DID INJURY OCCUR?                                               |

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                |  |                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|------------------------------------|
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                |  |                                    |
| ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D.                                                                                                                                                                                                                                                                                                                                                             |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                |  | DATE SIGNED <b>October 7, 1971</b> |
| EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>                                                                                                                                                                                                                                                                                                                                                      |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                               |  | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>            |  |                                    |

|                                                    |  |                                                      |  |                                                                     |  |                                               |  |
|----------------------------------------------------|--|------------------------------------------------------|--|---------------------------------------------------------------------|--|-----------------------------------------------|--|
| 24A. BURIAL CREMATION, REMOVAL (Specify)           |  | 24B. DATE <b>11-8-71</b>                             |  | 24C. NAME of CEMETERY or CREMATORY <b>ANATOMY BOARD OF MARYLAND</b> |  | 24D. LOCATION (City, town, or county) (State) |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>NOV 12 1971</b> |  | 25B. NAME OF REGISTRAR <b>Robert E. Fairley M.D.</b> |  | 25C. FUNERAL DIRECTOR                                               |  | ADDRESS                                       |  |
| UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD  |  |                                                      |  |                                                                     |  |                                               |  |

10001

ADMITTED

1948

10001

10

10001

10001

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                       |                             |                                                                                                                                                             |                                    | REG. NO. <b>71 10451</b>                                                                      |                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 7-625-71 10451                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |                                                                                                                                                             |                                    | CERTIFICATE OF DEATH                                                                          |                                                             |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Sadie Sarah Farson</b>                                                                                                                                                                                                                                                                                                                                                                                       |                             | 2. DATE AND HOUR OF DEATH<br><b>11-Nov-71 3:35 A.M.</b>                                                                                                     |                                    |                                                                                               |                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION <b>South Balt. Gen. Hosp.</b><br>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION                                                                                                                                                                                                                                                 |                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b><br>B. COUNTY <b>2101</b>                        |                                    |                                                                                               |                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                             | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                         |                                    | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                             | E. STREET AND NUMBER<br><b>838 Woodward St 4230</b>                                                                                                         |                                    |                                                                                               |                                                             |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. RACE<br><b>Caucasian</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4-24-97</b> | 9. AGE (in years last birthday)<br><b>74</b>                                                  | 10. Under 1 Yr. Months Days<br>11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Waitress</b>                                                                                                                                                                                                                                                                                                                                         |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>RESTAURANT</b>                                                                                                      |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                  |                                                             |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                             | 13. FATHER'S NAME<br><b>Frank Connelly</b>                                                                                                                  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Annie Carter</b>                                               |                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No/unknown</b>                                                                                                                                                                                                                                                                                                                          |                             | 16. SOCIAL SECURITY NO.<br><b>212-05-8106</b>                                                                                                               |                                    | 17. INFORMANT<br><b>R. Sirithara M.D. South Baltimore General Hosp</b>                        |                                                             |
| 18. <b>41231</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Ante pulmonary oedema</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Atrial fibrillation</b><br><b>Myocardial Infarction, old</b> |                             | CAUSE OF DEATH                                                                                                                                              |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |                                                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                                                 |                             |                                                                                                                                                             |                                    |                                                                                               |                                                             |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>                                                                                                |                                    | 20A. AUTOPSY? (Yes or No)<br><b>-</b>                                                         |                                                             |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>-</b>                                                                                                                                                                                                                                                                                                                                                                       |                             | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)<br><b>-</b>                                                           |                                    |                                                                                               |                                                             |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>-</b>                                                                                                                                                                                                                                                                                                                                                   |                             | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)<br><b>-</b>                                                                     |                                    |                                                                                               |                                                             |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br><b>-</b>                                                                                                                                                                                                                                                                                                                                                                                  |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                    | 21F. HOW DID INJURY OCCUR?<br><b>-</b>                                                        |                                                             |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11-10-1971</b> to <b>11-11-1971</b> that (I) (we) last saw the deceased alive on <b>11-11-1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                       |                             |                                                                                                                                                             |                                    |                                                                                               |                                                             |
| 23A. SIGNATURE<br><b>R. Sirithara</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                             | M.D. DEGREE                                                                                                                                                 |                                    | 23B. DATE SIGNED<br><b>11/11/71</b>                                                           |                                                             |
| 23C. PHYSICIAN'S NAME (Type)<br><b>SIRITHARA</b>                                                                                                                                                                                                                                                                                                                                                                                                       |                             | 23D. ADDRESS<br><b>M.D. South Baltimore General Hosp. 3001 S. Hancock St Baltimore Md.</b>                                                                  |                                    |                                                                                               |                                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                              |                             | 24B. DATE<br><b>11/13/71</b>                                                                                                                                |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><b>LOUDEN PARK CEMETERY</b>                             |                                                             |
| 24D. LOCATION (City, town, or county) (State)<br><b>WILKENS AVE. BALTO. MD.</b>                                                                                                                                                                                                                                                                                                                                                                        |                             | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b>                                                                                                       |                                    |                                                                                               |                                                             |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                |                             | 25C. FUNERAL DIRECTOR<br><b>MCCULLY FUNERAL HOME 130 E. FORT AVE 21230</b>                                                                                  |                                    |                                                                                               |                                                             |



D-362 71 10452

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 10452

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                             |                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)<br>Helen L. Dietrich                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  | 2. DATE OF DEATH<br>Estimated <input checked="" type="checkbox"/> 11 8 71 5:45 P.M.                                                                         |                                            |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION<br>11-23-71<br>1444 Walker Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  | 3. DATE PRONOUNCED DEAD<br>11 8 71 5:45 P. M.                                                                                                               |                                            |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland B. COUNTY Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland B. COUNTY Baltimore                              |                                            |
| 6. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 7. RACE<br>White | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | C. CITY OR TOWN<br>Baltimore               |
| 9. DATE OF BIRTH<br>June 26, 1913                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  | 10. AGE (in years last birthday)<br>58                                                                                                                      | E. STREET AND NUMBER<br>1444 Walker Avenue |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                      | 13. FATHER'S NAME<br>Frank Smith           |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Broker                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 14B. KIND OF BUSINESS OR INDUSTRY<br>Real Estate                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>Unknown        |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 17. SOCIAL SECURITY NO.<br>212 09 4035                                                                                                                      | 18. INFORMANT<br>Helen Dietrich            |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(A) IMMEDIATE CAUSE Alcoholism<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                     |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |                                            |
| 20A. DATE OF OPERATION<br>6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                            |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                            |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.)                                                                                                             |                                            |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | 22F. HOW DID INJURY OCCUR?                                                                                                                                  |                                            |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE: Werner U. Spitz, M.D.<br>EXAMINER'S NAME (Type) |                  |                                                                                                                                                             |                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  | 24B. DATE<br>11/10/71                                                                                                                                       |                                            |
| 24C. NAME OF CEMETERY or CREMATORY<br>Moreland Memorial Park                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore Balto. Maryland                                                                                  |                                            |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 12 1971                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, M.D.                                                                                                            |                                            |
| 25C. FUNERAL DIRECTOR<br>William E. Johnson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  | 25D. ADDRESS<br>Baltimore, Md.                                                                                                                              |                                            |

Letter from M. E. S. office.  
11-23-71 M. A.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-640 71 10453                                                                                                                                                                                                                                                                                                                                             |                         | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                    |                                      | REG. NO. 71 10453                                                                             |                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>BIRELY MARGARET M.</b>                                                                                                                                                                                                                                                                                           |                         | 2. DATE AND HOUR OF DEATH<br><b>4:30pm NOV 10. 71.</b>                                                                                                      |                                      |                                                                                               |                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                     |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND.</b> B. COUNTY <b>2302</b>                    |                                      |                                                                                               |                                                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>SOUTH BALTIMORE GENERAL HOSPITAL</b>                                                                                                                                                                                                                                                                            |                         | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                         |                                      | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                             |
| 3001. S. Hanover St. Balto. Md. 21230                                                                                                                                                                                                                                                                                                                      |                         | E. STREET AND NUMBER<br><b>9-EAST WHEELING ST.</b>                                                                                                          |                                      |                                                                                               |                                                             |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                    | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4-27-1901</b> | 9. AGE (In years last birthday)<br><b>70</b>                                                  | 10. Under 1 Yr. Months Days<br>11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                            |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>                                                                                                            |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                  |                                                             |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                              |                         | 13. FATHER'S NAME<br><b>John Long</b>                                                                                                                       |                                      | 14. MOTHER'S MAIDEN NAME<br><b>BABARA RICKETTS.</b>                                           |                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                      |                         | 16. SOCIAL SECURITY NO.<br><b>214-03-2178</b>                                                                                                               |                                      | 17. INFORMANT<br><b>CHART - SBGH</b>                                                          |                                                             |
| 18. <b>410.91-250.9</b>                                                                                                                                                                                                                                                                                                                                    |                         | CAUSE OF DEATH                                                                                                                                              |                                      |                                                                                               |                                                             |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                             |                         | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Gr Myocardial infarct</b>                                                                      |                                      |                                                                                               |                                                             |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                             |                         | (B) <b>Atherosclerotic Cardio Vascular</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>disorders</b>                                                           |                                      |                                                                                               |                                                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                     |                         | <b>Diabetes Mellitus</b>                                                                                                                                    |                                      |                                                                                               |                                                             |
| 19A. DATE OF OPERATION<br><b>NIL</b>                                                                                                                                                                                                                                                                                                                       |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NIL</b>                                                                                              |                                      | 20A. AUTOPSY (Yes or No)                                                                      |                                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                      |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                             |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                      | 21F. HOW DID INJURY OCCUR?                                                                    |                                                             |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-25</b> 19 <b>71</b> to <b>11-10</b> 19 <b>71</b> that <b>we</b> last saw the deceased alive on <b>4:30pm NOV 10 19 71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                      |                                                                                               |                                                             |
| 23A. SIGNATURE<br><b>Jany Chen</b>                                                                                                                                                                                                                                                                                                                         |                         | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                             |                                      | 23B. DATE SIGNED<br><b>NOV 10. 71</b>                                                         |                                                             |
| 23C. PHYSICIAN'S NAME (Type)<br><b>TAN YU CHENG MD</b>                                                                                                                                                                                                                                                                                                     |                         | 23D. ADDRESS<br><b>South Baltimore General Hosp.</b>                                                                                                        |                                      |                                                                                               |                                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                  |                         | 24B. DATE<br><b>11-13-71</b>                                                                                                                                |                                      | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>                                  |                                                             |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>                                                                                                                                                                                                                                                                                         |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b>                                                                                                       |                                      | 25B. NAME OF REGISTRAR<br><b>Robert E. Farber, M.D.</b>                                       |                                                             |
| 25C. FUNERAL DIRECTOR<br><b>McCully</b>                                                                                                                                                                                                                                                                                                                    |                         | ADDRESS<br><b>730 E. Fort Ave. 21230</b>                                                                                                                    |                                      |                                                                                               |                                                             |

10-10-12

10-10-12

Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.  
I am sorry to hear that you are having trouble with your engine.  
I will try to get it fixed as soon as possible.  
Very truly yours,  
J. H. Smith

I am sorry to hear that you are having trouble with your engine.  
I will try to get it fixed as soon as possible.  
Very truly yours,  
J. H. Smith

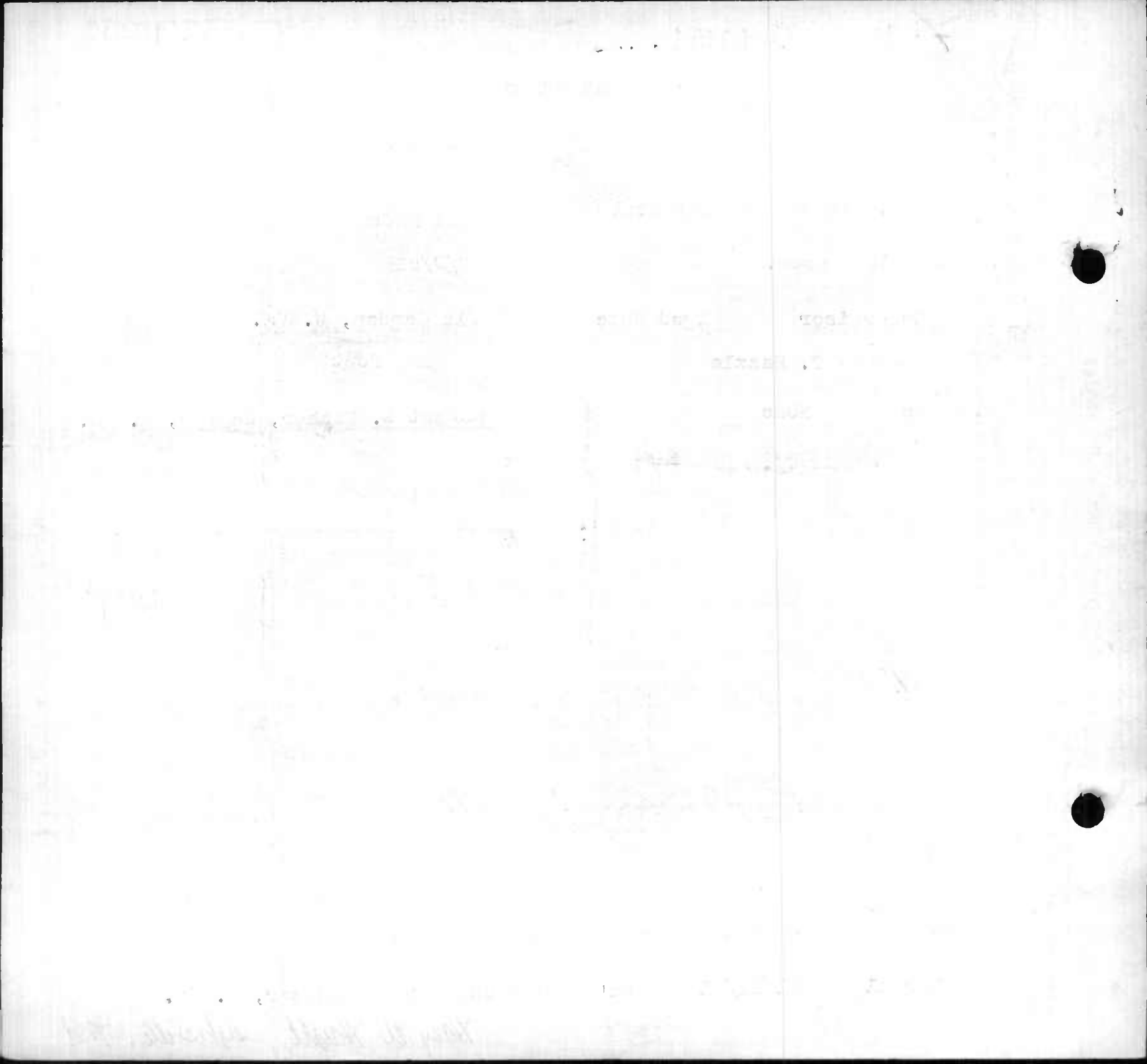
I am sorry to hear that you are having trouble with your engine.  
I will try to get it fixed as soon as possible.  
Very truly yours,  
J. H. Smith



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

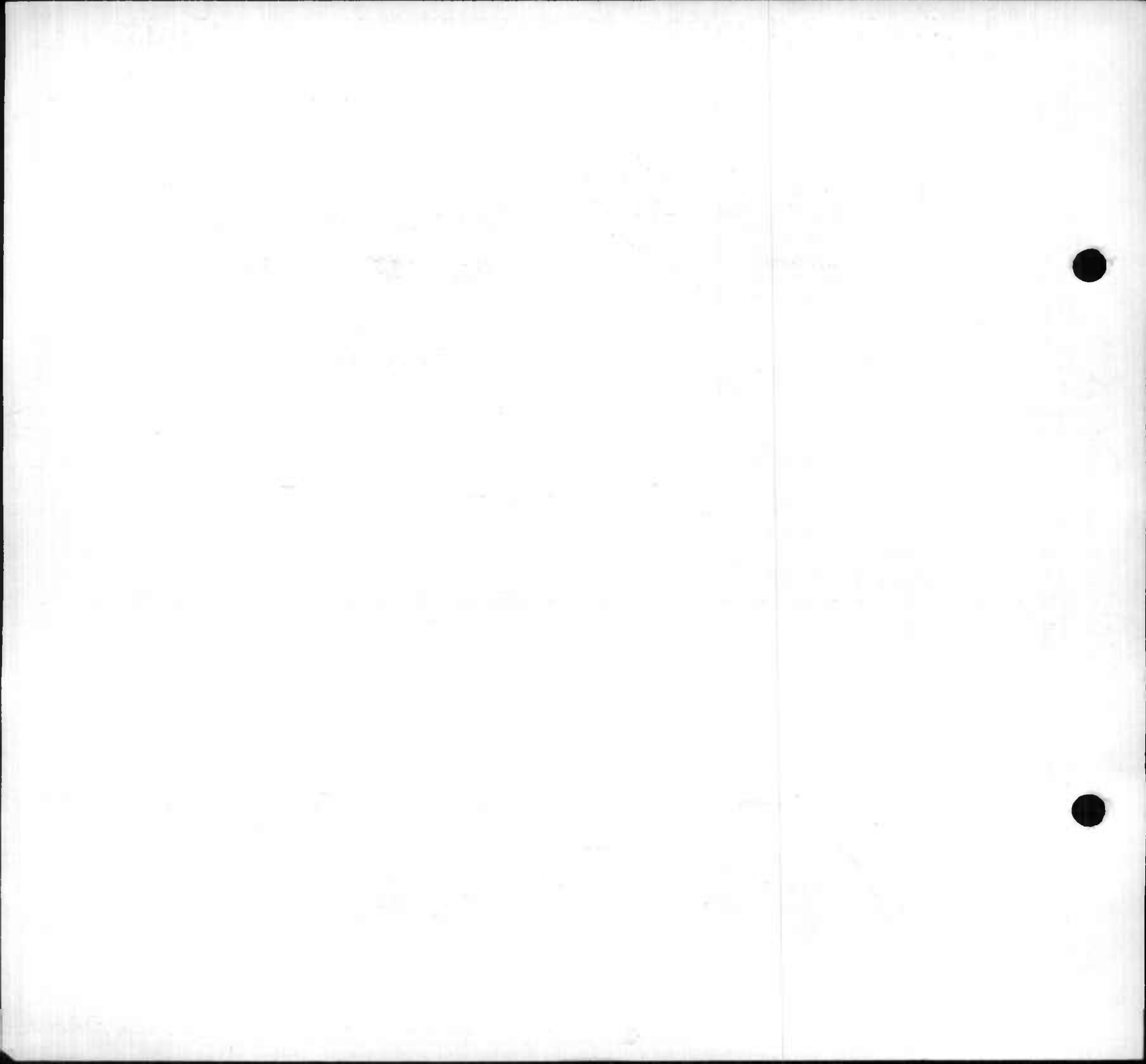
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                |                                                                 |                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------|
| 7-260 71 10454                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |                                                                                                                                                                                                                                                                                                | X REG. NO. 71 10454                                             |                                                                          |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                |                                                                 |                                                                          |
| 1. NAME OF DECEASED<br>(Type or Print) FISHER, Arvella Catherine                                                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br>11/9/71 7:12 a.m.                                                                                                                                                                                                                                                 |                                                                 |                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>33 The Johns Hopkins Hospital                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence below admission)<br>A. STATE Maryland B. COUNTY Baltimore<br>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 522 Alden Street |                                                                 |                                                                          |
| 5. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 6. RACE<br>Cacu. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>7/7/93                                                                                                                                                                                                                                                                     | 9. AGE (In years last birthday) 78                              | If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Supervisor                                                                                                                                                                                                                                                                                                                                                                     |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Aged Home                                                                                                              |                                                                                                                                                                                                                                                                                                | 11. BIRTHPLACE (State or foreign country)<br>Elk Garden, W. Va. |                                                                          |
| 13. FATHER'S NAME<br>William P. Bazzle                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                             | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                            |                                                                 |                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No None                                                                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                             | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                        |                                                                 | 17. INFORMANT<br>Robert L. Fisher, Keyser, W. Va.                        |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                  |                                                                                                                                                             | CAUSE OF DEATH<br>IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Cardio-vascular<br>CHF<br>Atherosclerosis<br>Unrel. Shunt down<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 hr.<br>1 wk.<br>4 days                                                                            |                                                                 |                                                                          |
| 19A. DATE OF OPERATION<br>11/1/71                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>perforated stomach                                                                                                                                                                                                                         |                                                                 | 20A. AUTOPSY (Yes or No)<br>YES                                          |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                       |                                                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                      |                                                                 | 21F. HOW DID INJURY OCCUR?                                               |
| 22. I certify that (I) (this hospital) attended the deceased from 11/1 to 11/9 1971 that (I) (we) last saw the deceased alive on 11/9 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                           |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                |                                                                 |                                                                          |
| 23A. SIGNATURE<br>Jerome E. Kurent                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                             | 23B. DATE SIGNED<br>11/9/71                                                                                                                                                                                                                                                                    |                                                                 | 23C. PHYSICIAN'S NAME (Type)<br>Jerome E. Kurent, M.D.                   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                             | 24B. DATE<br>11/11/71                                                                                                                                                                                                                                                                          |                                                                 | 24C. NAME of CEMETERY or CREMATORY<br>Queen's Point Cemetery             |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 12 1971                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                             | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, M.D.                                                                                                                                                                                                                                               |                                                                 | 25C. FUNERAL DIRECTOR<br>Henry W. Wright                                 |
| 24D. LOCATION<br>Keyser, W. Va.                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                                             | 24E. ADDRESS<br>Lyksville, Md.                                                                                                                                                                                                                                                                 |                                                                 |                                                                          |



**FUNERAL DIRECTOR: IMPORTANT**

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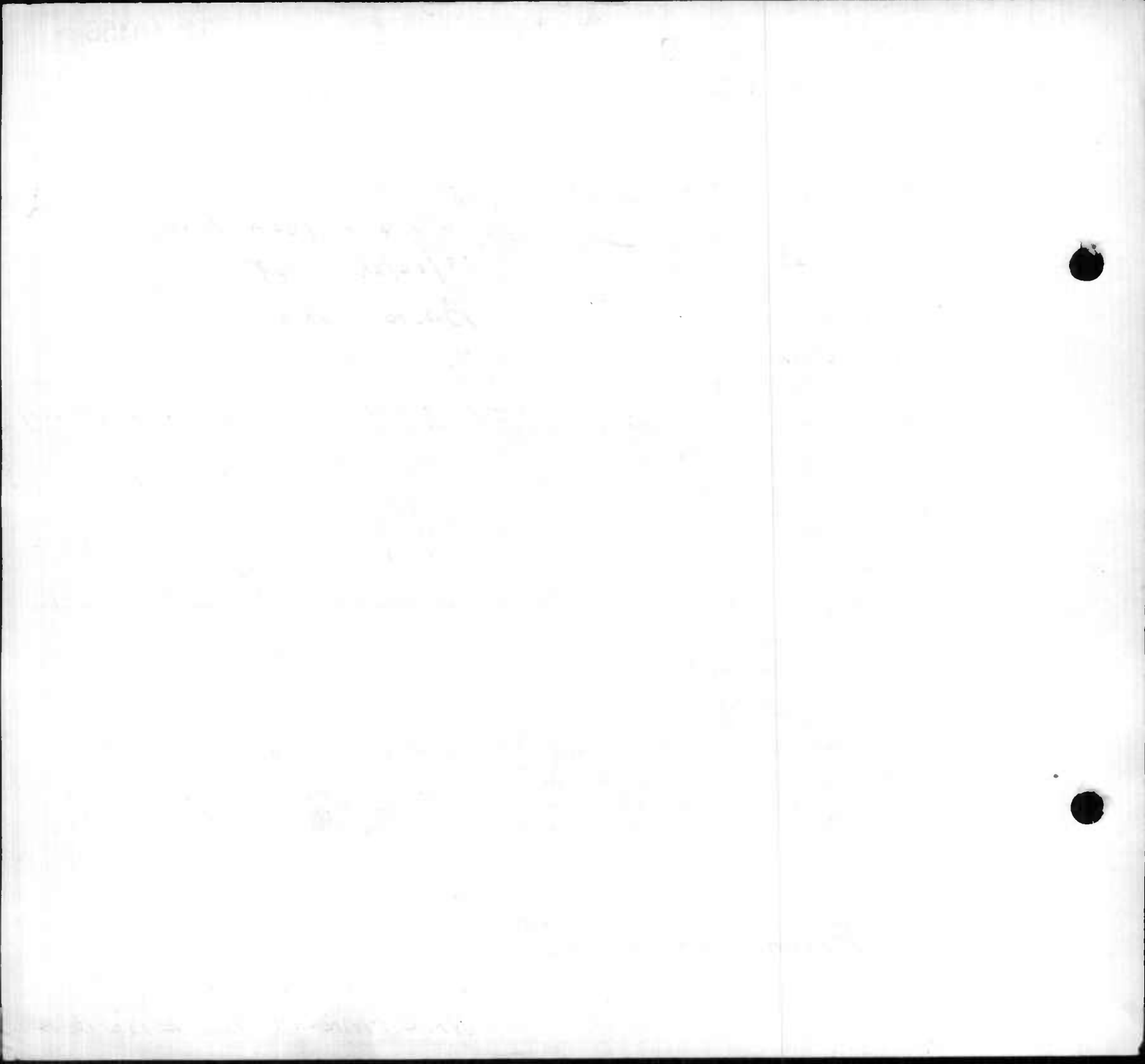
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             |                                                                                                                                                                              |                                          |                                                                                                                                                                                                                                                                                                                                                               |                                                              |                                                                                                   |                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-------------------------------------|
| <p><b>BIRTH NO.</b> 71 10455</p>                                                                                                                                                                                                                                                                                                                                                                                                                   |                             | <p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p>                                                                                                                               |                                          | <p><b>CERTIFICATE OF DEATH</b></p>                                                                                                                                                                                                                                                                                                                            |                                                              | <p><b>REG. NO.</b> 71 10455</p>                                                                   |                                     |
| <p>1. NAME OF DECEASED (Type or Print) <u>Louis Fallin</u></p>                                                                                                                                                                                                                                                                                                                                                                                     |                             |                                                                                                                                                                              |                                          | <p>2. DATE AND HOUR OF DEATH <u>November 10 1971</u> <u>10<sup>45</sup> A.M.</u></p>                                                                                                                                                                                                                                                                          |                                                              |                                                                                                   |                                     |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br/> <u>90 MT Sinai Nursing Home</u><br/> <u>4613 Park Heights Ave</u><br/> <u>Balto Md 21215</u></p>                                                                                                                                                                   |                             |                                                                                                                                                                              |                                          | <p>4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br/>         A. STATE <u>Maryland</u><br/>         B. COUNTY <u>843</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>1405 Kenhill Avenue</u></p> |                                                              |                                                                                                   |                                     |
| <p>5. SEX <u>Male</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                          | <p>6. RACE <u>Negro</u></p> | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br/>         WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> | <p>8. DATE OF BIRTH <u>11-15-89</u></p>  | <p>9. AGE (in years last birthday) <u>81</u></p>                                                                                                                                                                                                                                                                                                              | <p>If Under 1 Yr. Months: Days: Hours: Min.</p>              | <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> |                                     |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>                                                                                                                                                                                                                                                                                                                                                 |                             |                                                                                                                                                                              | <p>10B. KIND OF BUSINESS OR INDUSTRY</p> |                                                                                                                                                                                                                                                                                                                                                               | <p>11. BIRTHPLACE (State or foreign country) <u>M.D.</u></p> |                                                                                                   | <p>12. CITIZEN OF WHAT COUNTRY?</p> |
| <p>13. FATHER'S NAME <u>Louis Fallin</u></p>                                                                                                                                                                                                                                                                                                                                                                                                       |                             |                                                                                                                                                                              |                                          | <p>14. MOTHER'S MAIDEN NAME <u>Elizabeth Banner</u></p>                                                                                                                                                                                                                                                                                                       |                                                              |                                                                                                   |                                     |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>                                                                                                                                                                                                                                                                                                                                    |                             | <p>16. SOCIAL SECURITY NO. <u>212-09-9288</u></p>                                                                                                                            |                                          | <p>17. INFORMANT <u>EVA FALLIN</u></p>                                                                                                                                                                                                                                                                                                                        |                                                              | <p>ADDRESS <u>1405 KENHILL AVE</u></p>                                                            |                                     |
| <p>18. <u>43341</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH <u>Cerebral Thrombosis with Bilateral artery stenosis</u></p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last</p> |                             |                                                                                                                                                                              |                                          | <p>(A) IMMEDIATE CAUSE DUE TO OR AS A CONSEQUENCE OF: <u>with</u></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <u>non</u></p> <p>(C) <u>non</u></p>                                                                                                                                                                                                             |                                                              | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u></p>                                |                                     |
| <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>                                                                                                                                                                                                                                                                                                            |                             |                                                                                                                                                                              |                                          |                                                                                                                                                                                                                                                                                                                                                               |                                                              |                                                                                                   |                                     |
| <p>19A. DATE OF OPERATION <u>0</u></p>                                                                                                                                                                                                                                                                                                                                                                                                             |                             | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>                                                                                                                      |                                          | <p>20A. AUTOPSY? (Yes or No) <u>No</u></p>                                                                                                                                                                                                                                                                                                                    |                                                              | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>                       |                                     |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>                                                                                                                                                                                                                                                                                                                                                       |                             | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>                                                                              |                                          | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>                                                                                                                                                                                                                                                                               |                                                              |                                                                                                   |                                     |
| <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>                                                                                                                                                                                                                                                                                                                                                                                   |                             | <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>                                                                |                                          | <p>21F. HOW DID INJURY OCCUR?</p>                                                                                                                                                                                                                                                                                                                             |                                                              |                                                                                                   |                                     |
| <p>22. I certify that (I) (this hospital) attended the deceased from <u>Nov 30 1971</u> to <u>Nov 10 1971</u> that (I) (we) last saw the deceased alive on <u>Nov 10 1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.</p>                                                                                                               |                             |                                                                                                                                                                              |                                          |                                                                                                                                                                                                                                                                                                                                                               |                                                              |                                                                                                   |                                     |
| <p>23A. SIGNATURE <u>Manuel Levin M.D.</u></p>                                                                                                                                                                                                                                                                                                                                                                                                     |                             |                                                                                                                                                                              |                                          | <p>23B. DATE SIGNED <u>11/12/71</u></p>                                                                                                                                                                                                                                                                                                                       |                                                              | <p>23C. PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN M.D.</u></p>                                      |                                     |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>                                                                                                                                                                                                                                                                                                                                                                                      |                             | <p>24B. DATE <u>11-13-71</u></p>                                                                                                                                             |                                          | <p>24C. NAME OF CEMETERY or CREMATORY <u>Arbutus MEM PARK</u></p>                                                                                                                                                                                                                                                                                             |                                                              | <p>24D. LOCATION (City, town, or county) (State) <u>BALTO-15 MD</u></p>                           |                                     |
| <p>25A. DATE REC'D BY HEALTH DEPT. <u>NOV 12 1971</u></p>                                                                                                                                                                                                                                                                                                                                                                                          |                             | <p>25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u></p>                                                                                                                  |                                          | <p>25C. FUNERAL DIRECTOR <u>W.M. C. MARCH</u></p>                                                                                                                                                                                                                                                                                                             |                                                              | <p>ADDRESS <u>928 E NORTH AVE</u></p>                                                             |                                     |



**FUNERAL DIRECTOR: IMPORTANT**

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| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                               |                                  | 71 10456                                                                                                                                                                                                                                                                                                  |                                                           | 71 10456                                                                      |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------|--|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                               |                                  | BIRTH NO.                                                                                                                                                                                                                                                                                                 |                                                           | REG. NO.                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Alberta D. Gorham.</b>                                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                               |                                  | 2. DATE AND HOUR OF DEATH<br><b>11/16/71 2:10 P.M.</b>                                                                                                                                                                                                                                                    |                                                           |                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>39 Provoident Hospital</b>                                                                                                                                                                                                                             |                  |                                                                                                                                               |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>Prince Georges</b> C. CITY OR TOWN <b>PALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2616 LOYOLA N.W.</b> |                                                           |                                                                               |  |
| 5. SEX <b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                      | 6. RACE <b>B</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>12/26/26</b> | 9. AGE (In years last birthday) <b>44</b>                                                                                                                                                                                                                                                                 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |                                                                               |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dietician</b>                                                                                                                                                                                                                                                                                                                      |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>                                                                                          |                                  | 11. BIRTHPLACE (State or foreign country)<br><b>Balto Md</b>                                                                                                                                                                                                                                              |                                                           | 12. CITIZEN OF WHAT COUNTRY                                                   |  |
| 13. FATHER'S NAME<br><b>James Colbert</b>                                                                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                               |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Bessie Walton</b>                                                                                                                                                                                                                                                          |                                                           |                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                             |                  | 16. SOCIAL SECURITY NO.<br><b>231-36-4065</b>                                                                                                 |                                  | 17. INFORMANT<br><b>LEROY GORHAM 2616 Loyola northway</b>                                                                                                                                                                                                                                                 |                                                           |                                                                               |  |
| 18. <b>4307 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Subarachnoid Hemorrhage</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last<br><b>Possible Rupture intracranial aneurysm</b> |                  |                                                                                                                                               |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 days</b><br><b>Unknown</b>                                                                                                                                                                                                                           |                                                           |                                                                               |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                               |                                  |                                                                                                                                                                                                                                                                                                           |                                                           |                                                                               |  |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |                                  | 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                 |                                                           | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                      |                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                  |                                                           |                                                                               |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                            |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                        |                                  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                |                                                           |                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11/6</b> 19 <b>71</b> to <b>11/10</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>11/10</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                              |                  |                                                                                                                                               |                                  |                                                                                                                                                                                                                                                                                                           |                                                           |                                                                               |  |
| 23A. SIGNATURE<br><b>Eljah Saunders</b>                                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                               |                                  | 23B. DATE SIGNED                                                                                                                                                                                                                                                                                          |                                                           | 23C. PHYSICIAN'S NAME (Type) <b>MD ELJAH SAUNDERS</b>                         |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                            |                  | 24B. DATE<br><b>11-15-71</b>                                                                                                                  |                                  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Mt. Calvary Cem</b>                                                                                                                                                                                                                                              |                                                           | 24D. LOCATION (City, town, or county) (State)<br><b>Anne Arundel City Md.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b>                                                                                                                                                                                                                                                                                                                                                                                |                  | 25B. NAME OF REGISTRAR<br><b>Blair E. Taylor M.D.</b>                                                                                         |                                  | 25C. FUNERAL DIRECTOR<br><b>WM C MARCH 928 E North Ave</b>                                                                                                                                                                                                                                                |                                                           |                                                                               |  |



FUNERAL DIRECTOR: IMPORTANT

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E-12071 10457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 10457

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

THADDEUS Epps

2. DATE AND HOUR OF DEATH

Nov 10: 71

7:07 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

So. Baltimore General Hospital

43

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

C. CITY OR TOWN Baltimore

E. STREET AND NUMBER

4903 Crowson Avenue 21212

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

5. SEX

Male

6. RACE

Negro

7. MARRIED

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

3-9-06

9. AGE (in years last birthday)

65

10. UNDER 1 Yr.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

Nottaway Co., Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Gillian Epps

14. MOTHER'S MAIDEN NAME

Henrietta Graves

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Mary Epps 4903 Crowson Ave. 21212

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIAC ARREST

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MINUTES

(B)

DUE TO, OR AS A CONSEQUENCE OF:

SEVERE ACIDOSIS

DAYS

(C)

DUE TO, OR AS A CONSEQUENCE OF:

UREMIA (CHRONIC RENAL FAILURE)

MONTHS

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from DEC 29 1970 to Nov 10 1971 that (we) last saw the deceased alive on Nov 10 1971 and that (my) (applan death occurred on the date and hour and from the causes stated above. (I) (did) (view) the body after death.

23A. SIGNATURE

Edmund P. Garvey, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

Nov 10 - 71

23C. PHYSICIAN'S NAME (Type)

EDMUND P. GARVEY, M.D.

23D. ADDRESS

South Baltimore General Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11-15-71

24C. NAME OF CEMETERY OR CREMATORY

Maryland National Cemetery

24D. LOCATION

Laurel, Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 12 1971

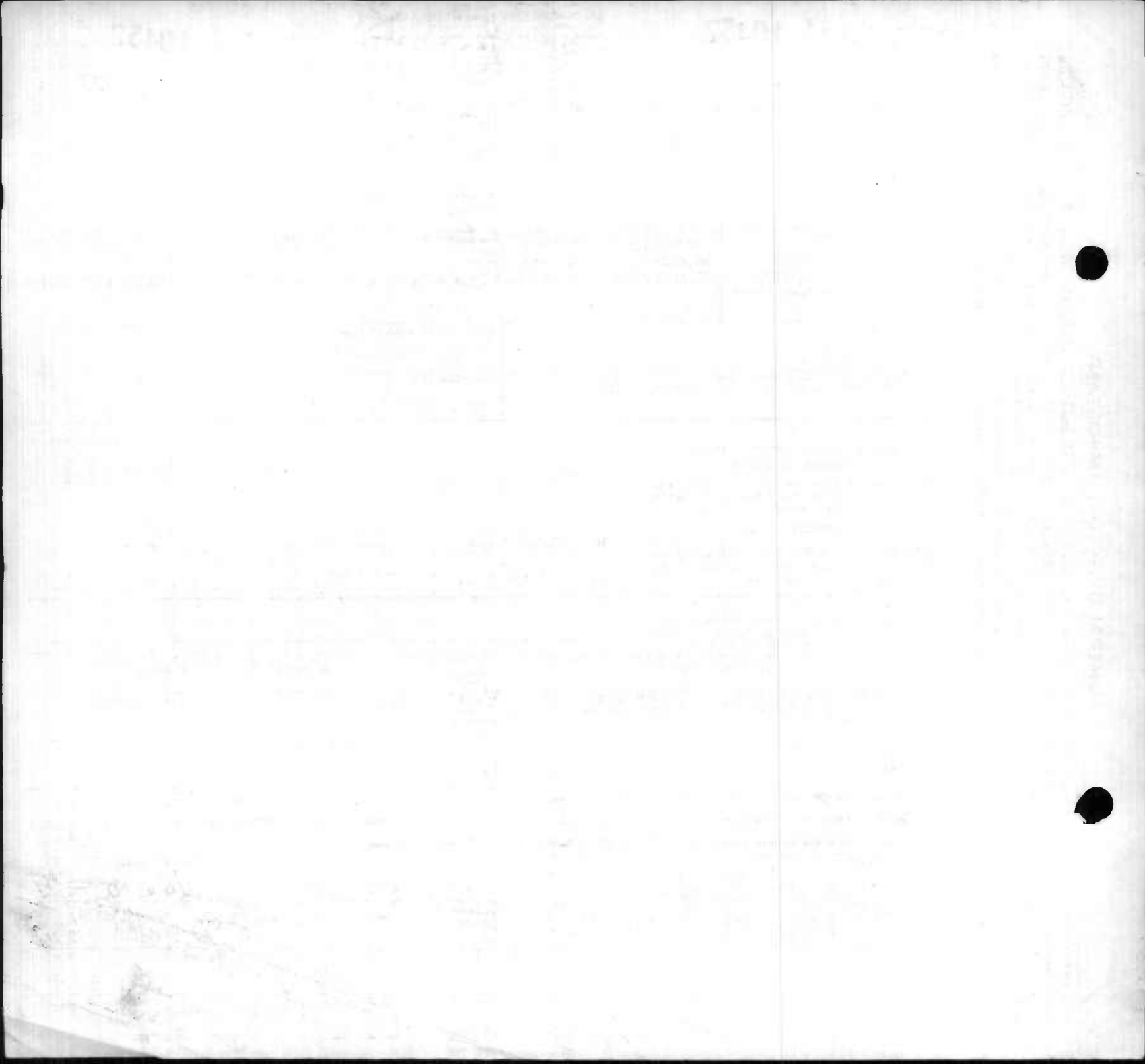
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

1735 Harford Ave. 21213

Marshall W. Jones, Jr.

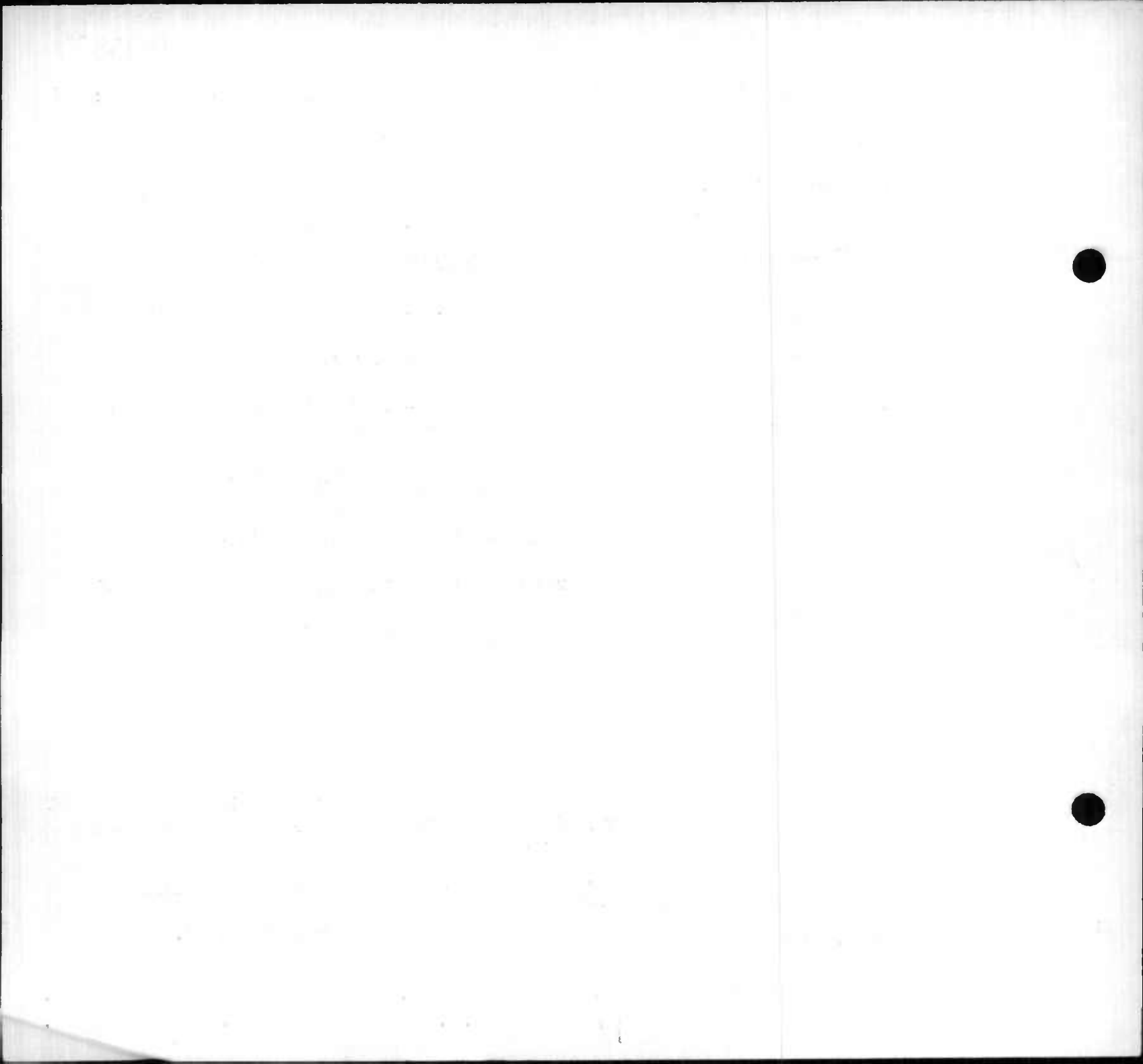




This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                     |                   |                                                                                                                                                          |                          | REG. NO. 71 10458                                                                                                    |                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|
| M-252 71 10458                                                                                                                                                                                                                                                                                                       |                   |                                                                                                                                                          |                          | CERTIFICATE OF DEATH                                                                                                 |                                                    |
| BIRTH NO.                                                                                                                                                                                                                                                                                                            |                   |                                                                                                                                                          |                          | 1. NAME OF DECEASED (Type or Print)                                                                                  |                                                    |
|                                                                                                                                                                                                                                                                                                                      |                   |                                                                                                                                                          |                          | Alexa Vay Mc Nicholas                                                                                                |                                                    |
| 2. DATE AND HOUR OF DEATH                                                                                                                                                                                                                                                                                            |                   |                                                                                                                                                          |                          | Nov. 10, 1971 9:30 P M.                                                                                              |                                                    |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                               |                   |                                                                                                                                                          |                          | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                |                                                    |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                            |                   |                                                                                                                                                          |                          | A. STATE Md. 1206                                                                                                    |                                                    |
| US Public Health Service Hospital<br>2X 3100 Wyman Parkway                                                                                                                                                                                                                                                           |                   |                                                                                                                                                          |                          | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                    |
| E. STREET AND NUMBER 5 E. 27th St.                                                                                                                                                                                                                                                                                   |                   |                                                                                                                                                          |                          |                                                                                                                      |                                                    |
| 5. SEX F                                                                                                                                                                                                                                                                                                             | 6. RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/15/92 | 9. AGE (in years last birthday) 79                                                                                   | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife                                                                                                                                                                                                                |                   | 10B. KIND OF BUSINESS OR INDUSTRY Own Home                                                                                                               |                          | 11. BIRTHPLACE (State or foreign country) W. Va.                                                                     |                                                    |
| 12. CITIZEN OF WHAT COUNTRY USA                                                                                                                                                                                                                                                                                      |                   | 13. FATHER'S NAME John T. Stanley                                                                                                                        |                          | 14. MOTHER'S MAIDEN NAME Addie B. Sinnet                                                                             |                                                    |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No                                                                                                                                                                                                          |                   | 16. SOCIAL SECURITY NO. 214-40-2683                                                                                                                      |                          | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.                                                           |                                                    |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                   |                   |                                                                                                                                                          |                          |                                                                                                                      |                                                    |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                       |                   |                                                                                                                                                          |                          |                                                                                                                      |                                                    |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                         |                   |                                                                                                                                                          |                          |                                                                                                                      |                                                    |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                    |                   |                                                                                                                                                          |                          |                                                                                                                      |                                                    |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                            |                   |                                                                                                                                                          |                          |                                                                                                                      |                                                    |
| (A) IMMEDIATE CAUSE Acute respiratory failure DUE TO, OR AS A CONSEQUENCE OF: Terminal                                                                                                                                                                                                                               |                   |                                                                                                                                                          |                          |                                                                                                                      |                                                    |
| (B) Myocardial infarction (acute) DUE TO, OR AS A CONSEQUENCE OF: 1 day                                                                                                                                                                                                                                              |                   |                                                                                                                                                          |                          |                                                                                                                      |                                                    |
| (C) Arteriosclerotic heart disease Unknown                                                                                                                                                                                                                                                                           |                   |                                                                                                                                                          |                          |                                                                                                                      |                                                    |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diverticulosis of the colon Unknown                                                                                                                                              |                   |                                                                                                                                                          |                          |                                                                                                                      |                                                    |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                               |                   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                          | 20A. AUTOPSY? (Yes or No) no                                                                                         |                                                    |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                |                   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                 |                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                             |                                                    |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                            |                   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                          | 21F. HOW DID INJURY OCCUR                                                                                            |                                                    |
| 22. I certify that (I) (this hospital) attended the deceased from Nov. 10 19 71 to Nov. 10 19 71 that (I) (we) last saw the deceased alive on Nov. 10 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                   |                                                                                                                                                          |                          |                                                                                                                      |                                                    |
| 23A. SIGNATURE Frank A. Hamilton, M.D. DEGREE                                                                                                                                                                                                                                                                        |                   |                                                                                                                                                          |                          | 23B. DATE SIGNED 11/11/71                                                                                            |                                                    |
| 23C. PHYSICIAN'S NAME (Type) Frank A. Hamilton, SA Surg (R) DEGREE                                                                                                                                                                                                                                                   |                   |                                                                                                                                                          |                          | 23D. ADDRESS US PHS Hospital, Balto, Md.                                                                             |                                                    |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                      |                   | 24B. DATE 11-15-71                                                                                                                                       |                          | 24C. NAME of CEMETERY or CREMATORY Baltimore National Cem. Baltimore Md.                                             |                                                    |
| 24D. LOCATION (City, town, or county) Baltimore                                                                                                                                                                                                                                                                      |                   | 24E. STATE                                                                                                                                               |                          | 25A. DATE REC'D BY HEALTH DEPT. 10V 12 1971                                                                          |                                                    |
| 25B. NAME OF REGISTRAR Robert E. Barber, R.D.                                                                                                                                                                                                                                                                        |                   | 25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212                                                                           |                          | 25D. ADDRESS                                                                                                         |                                                    |



C-623

71 10459

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 10459  
REG. NO.

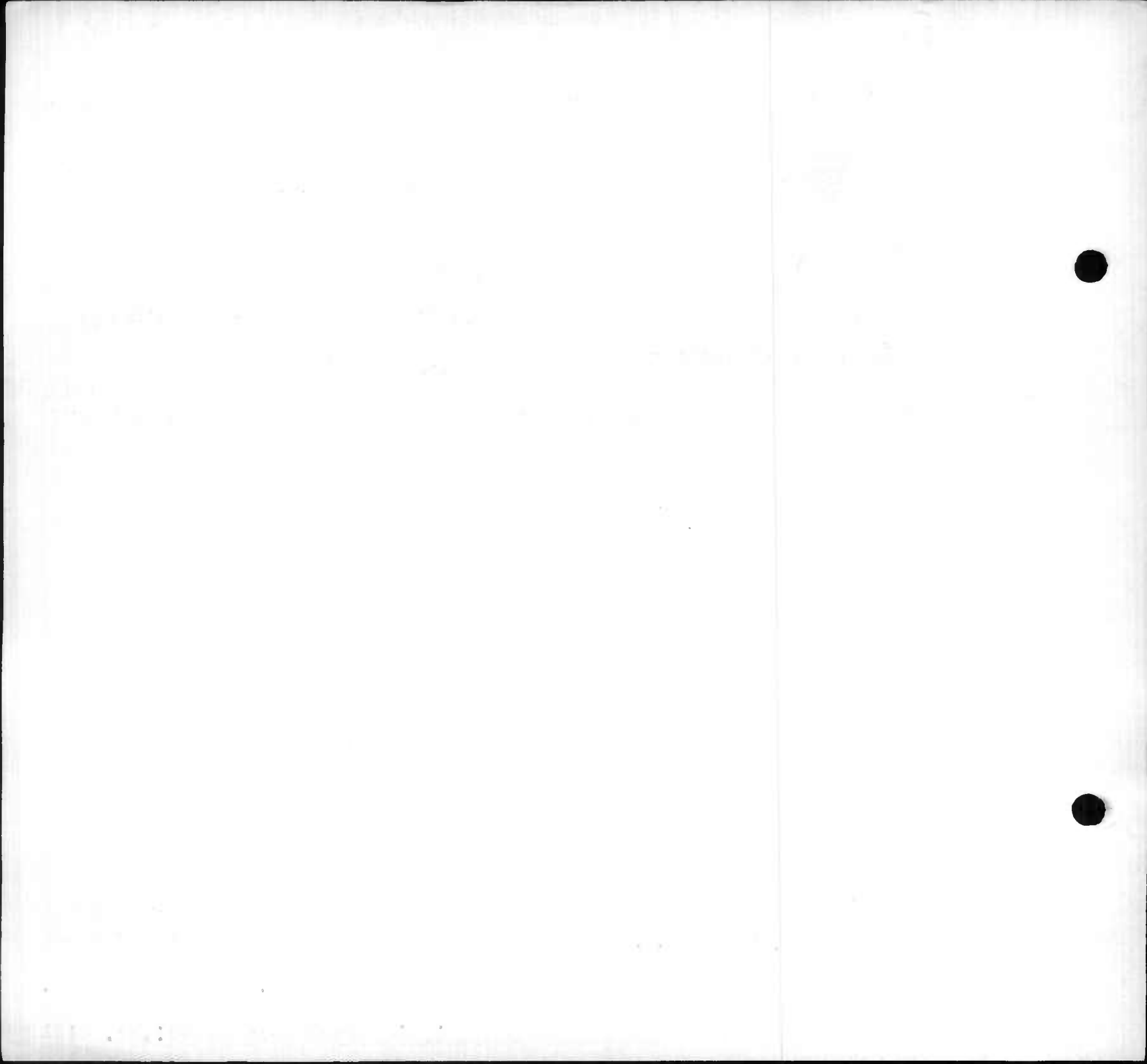
BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Hilmar B. Christianson, III</b>                                                                                                                                                                                                                                                                                                                                     |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.                                                                                                       |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>ADDRESS OR LOCATION<br><b>11-17-71</b><br><b>off of 3700 blk. Tudor Arms</b>                                                                                                                                                                                                                                |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>11 7 1971 10:10a</b> M.                                                                                                                                     |  |
| 6. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 7. RACE<br><b>white</b>                                                                                                                                                                                          |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                   |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                                                              |  |
| 9. DATE OF BIRTH<br><b>Feb. 16, 1953</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 10. AGE (In years lost birthday)<br><b>18</b>                                                                                                                                                                    |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Boston, Mass</b>                                                                                                                                                                                                                                                                                                                                              |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                    |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Student</b>                                                                                                                                                                                                                                                                                                 |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>                                                                                                                                                            |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                          |  | 17. SOCIAL SECURITY NO.                                                                                                                                                                                          |  |
| 18. INFORMANT<br><b>Hilmar B. Christianson, Jr.</b>                                                                                                                                                                                                                                                                                                                                                           |  | ADDRESS<br><b>(Same)</b>                                                                                                                                                                                         |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Close proximity gunshot wound of head</b>                                                                                                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                     |  |
| 20. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                            |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                           |  |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                          |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                              |  |
| 22. (C)                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                  |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                        |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                 |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                               |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>On Grass</b>                                                                                                      |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>found 3700 blk. Tudor Arms</b>                                                                                                                                                                                                                                                                                                 |  | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.)<br><b>11-?-71 ? m.</b>                                                                                                                                           |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                             |  | 22F. HOW DID INJURY OCCUR?<br><b>Undetermined Shot self in head</b>                                                                                                                                              |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                                                                                                  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>                                                                                                                                                                                                                                                                                                                                       |  | Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br><b>11-8-71</b> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                     |  | 24B. DATE<br><b>11/12/71</b>                                                                                                                                                                                     |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Druid Ridge</b>                                                                                                                                                                                                                                                                                                                                                      |  | 24D. LOCATION (City, town, or county) (State)<br><b>Pikesville, Balto. Co., Md.</b>                                                                                                                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b>                                                                                                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>                                                                                                                                                          |  |
| 25C. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>                                                                                                                                                                                                                                                                                                                                                   |  | ADDRESS<br><b>4905 York Rd. Balto., Md. 21212</b>                                                                                                                                                                |  |

Letter from M.E.'s office 11-17-71 M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              |                                                                                                                                                             |                               |                                                                                                                            |                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| F. 260 71 10460                                                                                                                                                                                                                                                                                                                                                                                                                                           |              | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                    |                               | REG. NO. 71 10460                                                                                                          |                                                           |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              | 1. NAME OF DECEASED<br>(Type or Print) Fisher - 1715 Sarah Barker                                                                                           |                               | 2. DATE AND HOUR OF DEATH<br>11-12-71 5a. M.                                                                               |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                    |              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland - Baltimore 5300<br>B. COUNTY                    |                               | C. CITY OR TOWN Owings Mills<br>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>91 Keswick                                                                                                                                                                                                                                                                                                                                                                                                        |              | E. STREET AND NUMBER<br>Chattolane                                                                                                                          |                               |                                                                                                                            |                                                           |
| 5. SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                                                                               | 6. RACE<br>W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>7-31-1879 | 9. AGE (In years last birthday)<br>92                                                                                      | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>None                                                                                                                                                                                                                                                                                                                                                       |              | 10B. KIND OF BUSINESS OR INDUSTRY<br>None                                                                                                                   |                               | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Md.                                                                |                                                           |
| 13. FATHER'S NAME<br>John A. Barker                                                                                                                                                                                                                                                                                                                                                                                                                       |              | 14. MOTHER'S MAIDEN NAME<br>Ella Patterson                                                                                                                  |                               | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                     |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                                                            |              | 16. SOCIAL SECURITY NO.<br>219-20-9983                                                                                                                      |                               | 17. INFORMANT<br>Keswick Records - 700 W. 40th St.                                                                         |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |              | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>Myocardial infarction<br>(B) Anteriosclerotic C-V disease<br>(C)                   |                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Hours<br>Years                                                             |                                                           |
| 19A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                                                                                                                                               |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                               | 20A. AUTOPSY? (Yes or No)<br>No                                                                                            |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examined)                                                                                                                                                                                                                                                                                                                                                                  |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                     |                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                   |                                                           |
| 21D. TIME OF INJURY (APPROX.)<br>1 (Month) (Day) 1 (Year) 1 (Hour)                                                                                                                                                                                                                                                                                                                                                                                        |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                               | 21F. HOW DID INJURY OCCUR?                                                                                                 |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from 8-18-71 to 11-12-71 that (I) (we) last saw the deceased alive on 11-12-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                      |              |                                                                                                                                                             |                               |                                                                                                                            |                                                           |
| 23A. SIGNATURE<br>RK Gundry MD                                                                                                                                                                                                                                                                                                                                                                                                                            |              | 23B. DATE SIGNED<br>11-12-71                                                                                                                                |                               | 23C. PHYSICIAN'S NAME (Type)<br>Richard K. Gundry, M.D.                                                                    |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                        |              | 24B. DATE<br>11-15-71                                                                                                                                       |                               | 24C. NAME OF CEMETERY or CREMATORY<br>Greenmount                                                                           |                                                           |
| 24D. LOCATION<br>Balto.                                                                                                                                                                                                                                                                                                                                                                                                                                   |              | 24E. CITY, TOWN, or county<br>Md.                                                                                                                           |                               | 24F. STATE<br>Md.                                                                                                          |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 12 1971                                                                                                                                                                                                                                                                                                                                                                                                            |              | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, R.D.                                                                                                            |                               | 25C. FUNERAL DIRECTOR<br>H. W. Jenkins & Sons Co.                                                                          |                                                           |
| 25D. ADDRESS<br>1905 York Road Balto., Md. 21212                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                             |                               |                                                                                                                            |                                                           |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                               |                     |                                                                                                                                                                                                                                     |                                       |                                                                          |                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------------------------|-------------------------------------------|
| D-200 71 10461                                                                                                                                                                                                                                                                                                                                                |                     | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                            |                                       | 71 10461                                                                 |                                           |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                     |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>MIRTIE A. DIX</b>                                                                                                                                                                         |                                       | 2. DATE AND HOUR OF DEATH<br><b>11/4/71 9:50 A</b>                       |                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                        |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>BALTO</b>                                                                                                  |                                       | 5. CITY OR TOWN <b>BALTO. MD.</b>                                        |                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>90 House of Pines Belair Rd.</b>                                                                                                                                                                                                                                                                                   |                     | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                       |                                       | E. STREET AND NUMBER<br><b>Belair Rd.</b>                                |                                           |
| 6. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                            | 7. RACE<br><b>W</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                         | 9. DATE OF BIRTH<br><b>10/20/1890</b> | 10. AGE (in years last birthday)<br><b>81</b>                            | 11. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                               |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>                                                                                                                                                                                       |                                       | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>             |                                           |
| 13. FATHER'S NAME<br><b>Andrew Murray</b>                                                                                                                                                                                                                                                                                                                     |                     | 14. MOTHER'S MAIDEN NAME<br><b>—</b>                                                                                                                                                                                                |                                       | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                               |                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes/no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                          |                     | 16. SOCIAL SECURITY NO.<br><b>215-54-7744</b>                                                                                                                                                                                       |                                       | 17. INFORMANT<br><b>Mrs. Berger</b>                                      |                                           |
| 18. CAUSE OF DEATH<br><b>412.31</b>                                                                                                                                                                                                                                                                                                                           |                     | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Anteroseptal Heart Disease</b> |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>year</b>              |                                           |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                |                     | (B) <b>Generalized Anteroseptal</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                              |                                       | <b>year</b>                                                              |                                           |
| (C) <b>—</b>                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                                                                                                     |                                       |                                                                          |                                           |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Chronic Brain Syndrome; Multiple Sclerosis</b>                                                                                                                                                                         |                     |                                                                                                                                                                                                                                     |                                       | <b>year</b>                                                              |                                           |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                            |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                    |                                       | 20A. AUTOPSY? (Yes or No)                                                |                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                                                                                             |                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                     |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                              |                                       | 21F. HOW DID INJURY OCCUR?                                               |                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>2/1/67</b> 19 <b>67</b> to <b>11/4/71</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>10/6/71</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |                                                                                                                                                                                                                                     |                                       |                                                                          |                                           |
| 23A. SIGNATURE<br><b>Albert B. Bradley</b>                                                                                                                                                                                                                                                                                                                    |                     | 23B. DATE SIGNED<br><b>11/4/71</b>                                                                                                                                                                                                  |                                       | 23C. PHYSICIAN'S NAME (Type)<br><b>Albert B. Bradley</b>                 |                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                     |                     | 24B. DATE<br><b>11/8/71</b>                                                                                                                                                                                                         |                                       | 24C. NAME OF CEMETERY or CREMATORY<br><b>St. Mary's - Conn</b>           |                                           |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTO. MD.</b>                                                                                                                                                                                                                                                                                            |                     | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 12 1971</b>                                                                                                                                                                               |                                       | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>                  |                                           |
| 25C. FUNERAL DIRECTOR<br><b>Joseph N. Zannone</b>                                                                                                                                                                                                                                                                                                             |                     | 25D. ADDRESS<br><b>2423 S. Condit</b>                                                                                                                                                                                               |                                       |                                                                          |                                           |

7/19/67 - A

825 Lannerton Rd.  
Balto., Md. 21220



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                           |                                                                                                                                     |                                                           |                                                                                                                                                             |
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| S-610 71 10462                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | BALTIMORE CITY HEALTH DEPARTMENT          |                                                                                                                                     | REG. NO. 71 10462                                         |                                                                                                                                                             |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                           |                                                                                                                                     |                                                           |                                                                                                                                                             |
| 1. NAME OF DECEASED<br>(Type or Print) <b>RALPH SHERBO (Raffak Scarbo)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                           | 2. DATE AND HOUR OF DEATH<br><b>11/5/71 530 A.M.</b>                                                                                |                                                           |                                                                                                                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Church Home &amp; Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                           | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MD</b><br>B. COUNTY <b>301</b> |                                                           |                                                                                                                                                             |
| 5. SEX <b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                           | 6. RACE <b>white</b>                                                                                                                |                                                           | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH <b>10/12/92</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 9. AGE (In years last birthday) <b>79</b> |                                                                                                                                     | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |                                                                                                                                                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>retired</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                           | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                   |                                                           | 11. BIRTHPLACE (State or foreign country) <b>Italy</b>                                                                                                      |
| 12. CITIZEN OF WHAT COUNTRY? <b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                           | 13. FATHER'S NAME <b>Frances Sherbo</b>                                                                                             |                                                           |                                                                                                                                                             |
| 14. MOTHER'S MAIDEN NAME <b>Cecilia Lammanna</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                           | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>                  |                                                           |                                                                                                                                                             |
| 16. SOCIAL SECURITY NO. <b>335620-123</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                           | 17. INFORMANT <b>pt's hos p. chart</b>                                                                                              |                                                           |                                                                                                                                                             |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ISCVD sen self kiln</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>minimonia bleeding from upper l. tract</b><br>19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>20A. AUTOPSY? (Yes or No) <b>no</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)<br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>21F. HOW DID INJURY OCCUR?<br>22. I certify that (I) (this hospital) attended the deceased from <b>10/24</b> 19 <b>71</b> to <b>11/5</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>11/5</b> 19 <b>71</b> and that (n(my) (aur) ap)lnan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.<br>23A. SIGNATURE <b>Dietrich von Teldmann MD</b> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 23B. DATE SIGNED <b>11/5/71</b><br>23C. PHYSICIAN'S NAME (Type) <b>DIETRICH VON TELDMANN MD</b> 23D. ADDRESS <b>CHURCH HOME &amp; HOSP.</b><br>24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b> 24B. DATE <b>NOV 13, 1971</b> 24C. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b> 24D. LOCATION (City, town, or county) (State) <b>Thoen/Hill Ontario Canada</b><br>25A. DATE REC'D BY HEALTH DEPT. <b>NOV 12 1971</b> 25B. NAME OF REGISTRAR <b>Robert E. Fisher MD</b> 25C. FUNERAL DIRECTOR <b>Joseph Lammanna</b> ADDRESS <b>263 S. Conkling St. Baltimore, Md.</b> |  |                                           |                                                                                                                                     |                                                           |                                                                                                                                                             |

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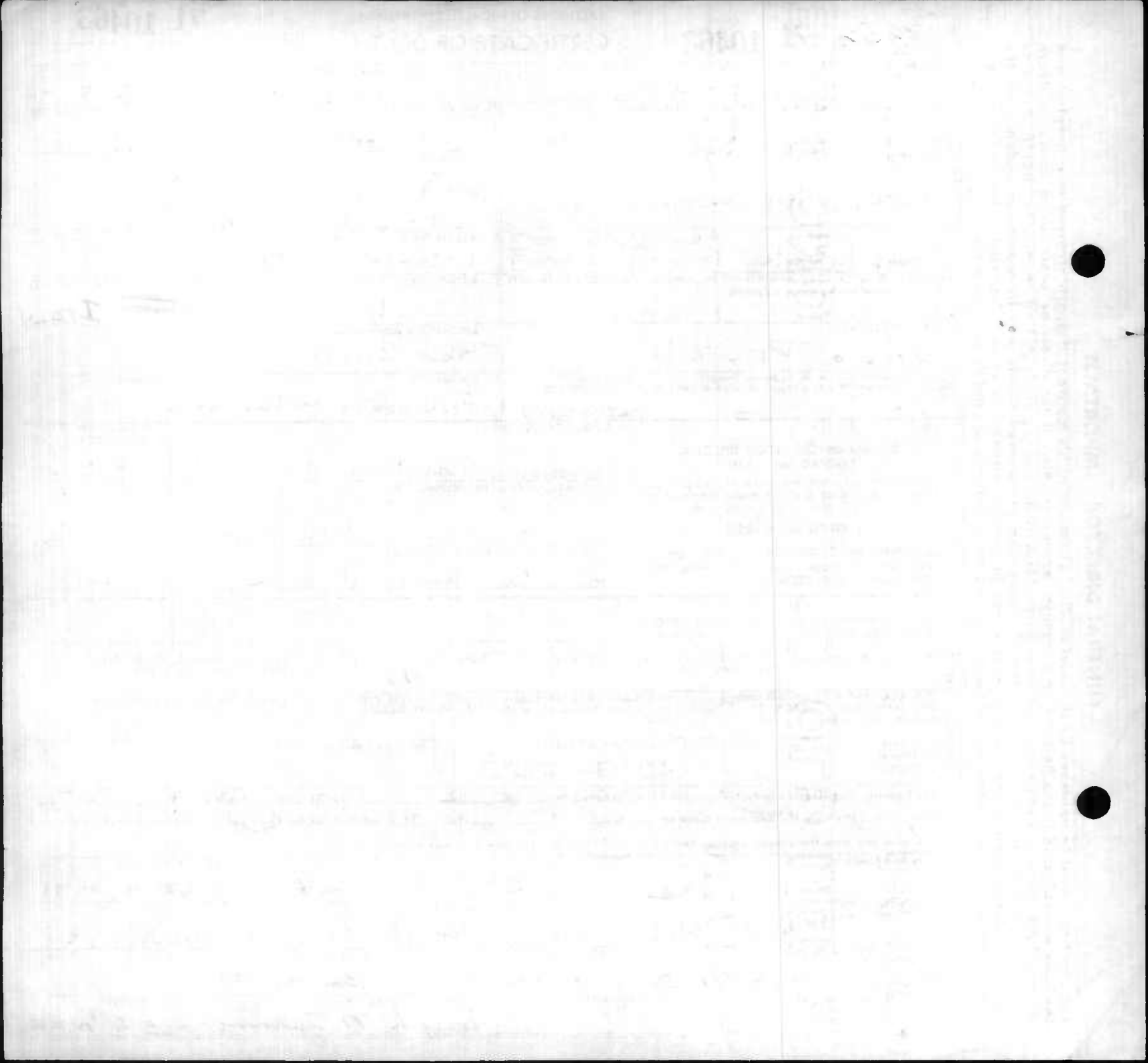
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |                                                                                                                                                                                                  | 71 10463                                                                 |                                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| T-636 71 10463                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |                                                                                                                                                                                                  | REG. NO.                                                                 |                                                                                                                                                             |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                           |                                                                                                                                                                                                  | 71 10463                                                                 |                                                                                                                                                             |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Turturro, Anna</u>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                           | 2. DATE AND HOUR OF DEATH<br><u>Nov. 4, 1971</u> <u>12:05 A.M.</u>                                                                                                                               |                                                                          |                                                                                                                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Mercy Hospital</u>                                                                                                                                                                                                |  |                                                                                                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>2605</u>                                                       |                                                                          |                                                                                                                                                             |
| 5. SEX <u>Female</u>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           | 6. RACE <u>White</u>                                                                                                                                                                             |                                                                          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                                                                                                                                                                 |  |                                                                                                           | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>home</u>                                                                                                                                                 |                                                                          | 8. DATE OF BIRTH<br><u>5-20-85</u>                                                                                                                          |
| 13. FATHER'S NAME<br><u>Nicola Piscitelli</u>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           | 14. MOTHER'S MAIDEN NAME<br><u>Rose Cirillo</u>                                                                                                                                                  |                                                                          | 9. AGE (in years last birthday) <u>86</u><br>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                                                         |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                                                           |  |                                                                                                           | 16. SOCIAL SECURITY NO.<br><u>067-08-2507</u>                                                                                                                                                    |                                                                          | 11. BIRTHPLACE (State or foreign country)<br><u>Italy</u>                                                                                                   |
| 17. INFORMANT<br><u>Fr. Vincent M. Turturro</u>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                           | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA ITALY</u>                                                                                                                                                 |                                                                          |                                                                                                                                                             |
| 18. CAUSE OF DEATH<br><u>579.21</u>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                     |                                                                          |                                                                                                                                                             |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                            |  |                                                                                                           | (A) IMMEDIATE CAUSE <u>Aspiration pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) <u>Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) <u>Ch. lung disease</u> |                                                                          |                                                                                                                                                             |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                |  |                                                                                                           |                                                                                                                                                                                                  |                                                                          |                                                                                                                                                             |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                                                              |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |                                                                                                                                                                                                  | 20A. AUTOPSY? (Yes or No)<br><u>No</u>                                   |                                                                                                                                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                           |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                                                                                                                                                                                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                                                                                                             |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                       |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                                                                                                                                                                                  | 21F. HOW DID INJURY OCCUR?                                               |                                                                                                                                                             |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Oct. 12</u> 19 <u>71</u> to <u>Nov. 4</u> 19 <u>71</u> that (I) <u>(we)</u> last saw the deceased alive on <u>Nov. 4</u> 19 <u>71</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death. |  |                                                                                                           |                                                                                                                                                                                                  |                                                                          |                                                                                                                                                             |
| 23A. SIGNATURE<br><u>John Ohe MD</u>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |                                                                                                                                                                                                  | 23B. DATE SIGNED<br><u>Nov. 4, 1971</u>                                  |                                                                                                                                                             |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Tohrv OHE MD</u>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |                                                                                                                                                                                                  | 23D. ADDRESS<br><u>Mercy Hospital, Baltimore</u>                         |                                                                                                                                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                       |  | 24B. DATE<br><u>11/8/71</u>                                                                               |                                                                                                                                                                                                  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Sacred Heart</u>                |                                                                                                                                                             |
| 24D. LOCATION<br><u>Balto. Md.</u>                                                                                                                                                                                                                                                                                                                                                              |  | 24E. NAME OF REGISTRAR<br><u>Joseph R. Zarnio</u>                                                         |                                                                                                                                                                                                  | 24F. FUNERAL DIRECTOR<br><u>263 S. Park</u>                              |                                                                                                                                                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 12 1971</u>                                                                                                                                                                                                                                                                                                                                           |  | 25B. NAME OF REGISTRAR<br><u>Joseph R. Zarnio</u>                                                         |                                                                                                                                                                                                  | 25C. FUNERAL DIRECTOR<br><u>263 S. Park</u>                              |                                                                                                                                                             |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                               | REG. NO. <u>71 10464</u>                                                    |                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------|
| S-432 71 10464                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                               | CERTIFICATE OF DEATH                                                        |                                                                          |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Mrs Marie Shields</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                      |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><u>11/12/71</u> <u>6:15 A.M.</u>                                                                                                                                                                                                                                                 |                                                                             |                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Hood Convalescent Home</u><br><u>5313 Edmondson Ave. Balto 21229</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>md</u> B. COUNTY <u>Balto</u><br>C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>417 Edsdale Road</u> |                                                                             |                                                                          |
| 5. SEX <u>Female</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/19/1893</u>                                                                                                                                                                                                                                                                            | 9. AGE (In years last birthday) <u>78</u>                                   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                      |                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>                                                                                                                                                                                                                                                     |                                                                             | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                  |
| 13. FATHER'S NAME <u>John T. McNally</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME <u>Marie McNally</u>                                                                                                                                                                                                                                                                 |                                                                             |                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      |                                                                                                                                                             | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                       | 17. INFORMANT ADDRESS<br><u>Mr. Albert B. Shields, Sr. 417 Edsdale Road</u> |                                                                          |
| 18. <u>412.4 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><br>19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><br>20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><br>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)<br><br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)<br><br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><br>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)<br><br>21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/><br><br>21F. HOW DID INJURY OCCUR?<br><br><u>THROMBOSIS -</u><br><u>PNEUMONIA PNEUMIC</u> |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                               |                                                                             |                                                                          |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> 19 <u>88</u> to <u>11/12</u> 19 <u>71</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>11/12</u> 19 <u>71</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                               |                                                                             |                                                                          |
| 23A. SIGNATURE <u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                                             | 23B. DATE SIGNED <u>11/12/71</u>                                                                                                                                                                                                                                                                              |                                                                             | 23C. PHYSICIAN'S NAME (Type) <u>Edwin H. Shaw</u>                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      |                                                                                                                                                             | 24B. DATE <u>11/15/71</u>                                                                                                                                                                                                                                                                                     | 24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>            | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>NOV 15 1971</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                                             | 25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>                                                                                                                                                                                                                                                           |                                                                             | 25C. FUNERAL DIRECTOR ADDRESS <u>Witzke, 1630 Edmondson Ave., 2228</u>   |

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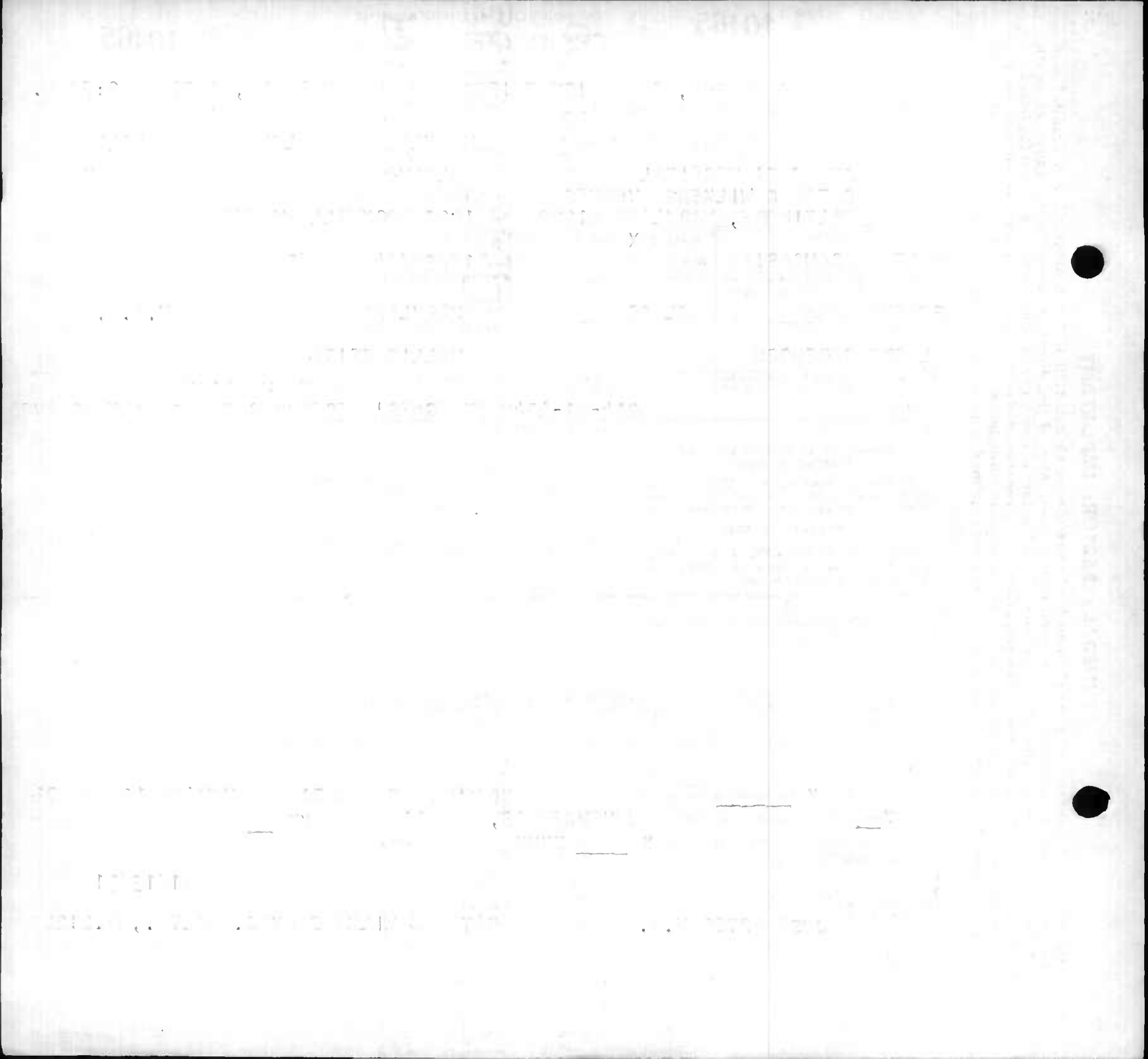
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                              |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                          | REG. NO. 71 10465                                                        |                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------------------|
| BIRTH NO. 8-65271 10465                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                          |                                                                          |                                                               |
| 1. NAME OF DECEASED<br>(Type or Print) SORESEN, FREDERICK GEISER                                                                                                                                                                                                                                                              |                      |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br>NOVEMBER 13, 1971 2:50 A.M.                                                                                                                                                                                                                                                 |                                                                          |                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>40 ST AGNES HOSPITAL<br>CATON & WILKENS AVENUES<br>BALTIMORE, MARYLAND 21229                                                                           |                      |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE MARYLAND B. COUNTY BALTIMORE<br>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER 1925 ROCKWELL AVENUE 5300 |                                                                          |                                                               |
| 5. SEX<br>MALE                                                                                                                                                                                                                                                                                                                | 6. RACE<br>CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>10/30/04                                                                                                                                                                                                                                                                             | 9. AGE (In years last birthday)<br>67                                    | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>FOREMAN                                                                                                                                                                                                                        |                      |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br>GLASS                                                                                                                                                                                                                                                               |                                                                          | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND         |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                                        |                      |                                                                                                                                                             | 13. FATHER'S NAME<br>ALBERT SORESEN                                                                                                                                                                                                                                                                      |                                                                          |                                                               |
| 14. MOTHER'S MAIDEN NAME<br>MOLLIE GEISER                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                                             | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO                                                                                                                                                                                           |                                                                          |                                                               |
| 16. SOCIAL SECURITY NO.<br>214-01-4742                                                                                                                                                                                                                                                                                        |                      |                                                                                                                                                             | 17. INFORMANT<br>BALTO MD 21229<br>ST AGNES' RECORDS CATON & WILKENS AVES                                                                                                                                                                                                                                |                                                                          |                                                               |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ACUTE PULMONARY INFECTION<br>SCORDED INFECTED<br>1 hr                                                                     |                      |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 yrs.                                                                                                                                                                                                                                                  |                                                                          |                                                               |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                            |                      |                                                                                                                                                             | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>ASCVD<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____                                                                                                                                                                                      |                                                                          |                                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                        |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                          |                                                                          |                                                               |
| 19A. DATE OF OPERATION<br>2                                                                                                                                                                                                                                                                                                   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                          | 20A. AUTOPSY? (Yes or No)<br>YES                                         |                                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                         |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                     |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                                                                                                                          | 21F. HOW DID INJURY OCCUR?                                               |                                                               |
| 22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 9 19 71 to NOVEMBER 13 19 71 that (X) (we) last saw the deceased alive on NOVEMBER 13, 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death. |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                          |                                                                          |                                                               |
| 23A. SIGNATURE<br>JOSE APTER M.D.                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                             | 23B. DATE SIGNED<br>11/13/71                                                                                                                                                                                                                                                                             |                                                                          | 23C. PHYSICIAN'S NAME (Type)<br>JOSE APTER M.D.               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                            |                      |                                                                                                                                                             | 24B. DATE<br>11/16/71                                                                                                                                                                                                                                                                                    |                                                                          | 24C. NAME of CEMETERY or CREMATORY<br>Loudon Park Cemetery    |
| 24D. LOCATION (City, town, or county)<br>Baltimore, Maryland                                                                                                                                                                                                                                                                  |                      |                                                                                                                                                             | 24E. STATE (State)<br>Maryland                                                                                                                                                                                                                                                                           |                                                                          |                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 15 1971                                                                                                                                                                                                                                                                                |                      |                                                                                                                                                             | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, M.D.                                                                                                                                                                                                                                                         |                                                                          | 25C. FUNERAL DIRECTOR<br>Witzke, 1630 Edmondson Ave., 21228   |







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             |                                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------|
| <b>R-140</b><br><b>71 10466</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             | <b>BALTIMORE CITY HEALTH DEPARTMENT</b><br><b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                  |                                                                  | <b>REG. NO. 71 10466</b>                                                                       |                                              |
| <b>BIRTH NO.</b><br>1. NAME OF DECEASED<br>(Type or Print) <b>RUPPEL MADELINE ELIZABETH</b>                                                                                                                                                                                                                                                                                                                                                                        |                             | 2. DATE AND HOUR OF DEATH<br><b>11/13/71</b> <b>10:32AM</b> M.                                                                                                                                                                                                                                                          |                                                                  |                                                                                                |                                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>40 ST AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                  |                             | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2802</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER<br><b>3505 MILFORD AVENUE</b> |                                                                  |                                                                                                |                                              |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6. RACE<br><b>CAUCASION</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                             |                                                                  | 8. DATE OF BIRTH<br><b>10/15/12</b>                                                            | 9. AGE (In years last birthday)<br><b>59</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>                                                                                                                                                                                                                                                                                                                                                    |                             | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                       |                                                                  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b> |
| 13. FATHER'S NAME<br><b>JAMES MURPHY</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                             | 14. MOTHER'S MAIDEN NAME<br><b>MARY HELBIG</b>                                                                                                                                                                                                                                                                          |                                                                  |                                                                                                |                                              |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                           |                             | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                 | 17. INFORMANT ADDRESS<br><b>ST AGNES HOSPITAL BALTO MD 21229</b> |                                                                                                |                                              |
| 18. <b>15-3-11</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                |                             | <b>CAUSE OF DEATH</b><br><b>GRAM-NEGATIVE SEPTIC SHOCK</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>MASSIVE BRONCHOPNEUMONIA</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Metap: obstructing CA of Spleenic</b><br>(C) <b>FLUXUS</b>                                                         |                                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 days</b><br><b>5 days</b><br><b>4 wks</b> |                                              |
| <b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>HYPERTENSIVE CARDIO VASCULAR DISEASE</b><br><b>CHRONIC COMPENSATORY RENAL FAILURE</b>                                                                                                                                                                                                                          |                             | <b>unknown</b>                                                                                                                                                                                                                                                                                                          |                                                                  |                                                                                                |                                              |
| 19A. DATE OF OPERATION<br><b>NOV. 5, 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma @ Colon</b>                                                                                                                                                                                                                                            |                                                                  | 20A. AUTOPSY? (Yes or No)<br><b>NO.</b>                                                        |                                              |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                                               |                             | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                          |                                                                  |                                                                                                |                                              |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                           |                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                |                                                                  | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                      |                                              |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                             |                             | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                              |                                                                  |                                                                                                |                                              |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/01/71</b> 19 to <b>11/13/71</b> 19 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/13/71</b> 19 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. |                             |                                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                |                                              |
| 23A. SIGNATURE<br><b>Southorn Malaisrie</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |                             | 23B. DATE SIGNED<br><b>NOV 13 1971</b>                                                                                                                                                                                                                                                                                  |                                                                  | 23C. PHYSICIAN'S NAME (Type)<br><b>SOUTHORN MALAISRIE MD</b>                                   |                                              |
| 23D. ADDRESS<br><b>4. Agnes Hosp</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |                             | 24A. SURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                               |                                                                  |                                                                                                |                                              |
| 24B. DATE<br><b>11/17/71</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                             | 24C. NAME OF CEMETERY OR CREMATORY<br><b>hendon Park</b>                                                                                                                                                                                                                                                                |                                                                  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b>                           |                                              |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 15 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                              |                             | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, MD</b>                                                                                                                                                                                                                                                                   |                                                                  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>1630 Edmondson Ave</b>                                     |                                              |

THE UNIVERSITY OF

THE STATE OF

NEW YORK

IN SENATE

JANUARY 1, 1901

REPORT

OF THE

COMMISSIONER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

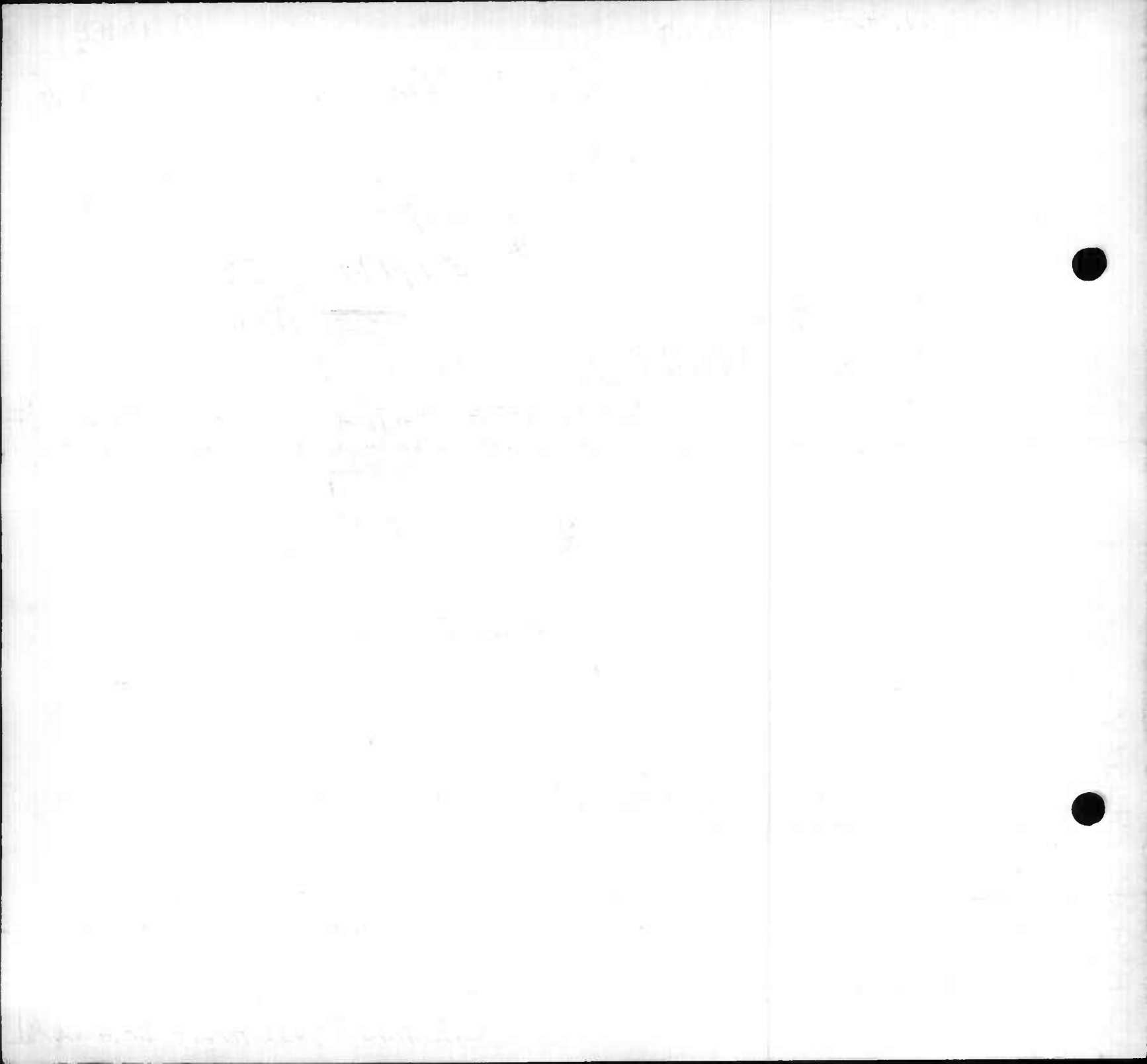
|                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|
| S-610 71 10467                                                                                                                                                                                                                                                                                                                                |  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                              |  | REG. NO. 71 10467                                                                                                            |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                     |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Annie A. Sharp</u>                                                                                                                                                                                                                                                                          |  | 2. DATE AND HOUR OF DEATH<br><u>11/11/71</u> <u>8:30 P.M.</u>                                                                |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>90 Hood Museum Home</u><br><u>5313 Edmondson Ave</u>                                                                                                            |  | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)<br>A. STATE <u>MD</u> B. COUNTY <u>2834</u>                                                                                                                                                                                                     |  | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                            |  | 8. DATE OF BIRTH <u>10/15/88</u> 9. AGE (In years last birthday) <u>83</u>                                                                                                                                                                                                                                                            |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY |  |
| 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>                                                                                                                                                                                                                                                                                 |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                                                                                                                                                                                                                                                                               |  | 13. FATHER'S NAME <u>John Long</u>                                                                                           |  |
| 14. MOTHER'S MAIDEN NAME <u>Mary L</u>                                                                                                                                                                                                                                                                                                        |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                              |  | 16. SOCIAL SECURITY NO.                                                                                                      |  |
| 17. INFORMANT <u>Mr. William Humphreys, 723 Cooks Lane</u>                                                                                                                                                                                                                                                                                    |  | ADDRESS                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                              |  |
| 18. <u>1950</u> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                |  | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u><br><u>months</u>                                              |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                              |  |
| 19A. DATE OF OPERATION <u>11/11/71</u>                                                                                                                                                                                                                                                                                                        |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                      |  | 20A. AUTOPSY? (Yes or No) <input type="checkbox"/>                                                                           |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                              |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                     |  |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                     |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                             |  | 21F. HOW DID INJURY OCCUR?                                                                                                   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1968</u> to <u>11/11/71</u> 19 <u>71</u> that (I) <u>last</u> saw the deceased alive on <u>11/5/71</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death. |  |                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                              |  |
| 23A. SIGNATURE <u>James J. Nolan</u>                                                                                                                                                                                                                                                                                                          |  | 23B. DATE SIGNED <u>11/11/71</u>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                              |  |
| 23C. PHYSICIAN'S NAME (Type) <u>J. J. NOLAN</u>                                                                                                                                                                                                                                                                                               |  | 23D. ADDRESS <u>Baltimore Maryland 21229</u>                                                                                                                                                                                                                                                                                          |  |                                                                                                                              |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                                                                                                                                                                                                        |  | 24B. DATE <u>11/15/71</u>                                                                                                                                                                                                                                                                                                             |  | 24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>                                                               |  |
| 24D. LOCATION <u>Baltimore, Maryland</u>                                                                                                                                                                                                                                                                                                      |  | 24E. ADDRESS                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                              |  |
| 25A. DATE REC'D BY HEALTH DEPT. <u>NOV 15 1971</u>                                                                                                                                                                                                                                                                                            |  | 25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>                                                                                                                                                                                                                                                                                  |  | 25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Ave., 21228</u>                                                              |  |

✓  
Bolt

FUNERAL DIRECTOR: IMPORTANT

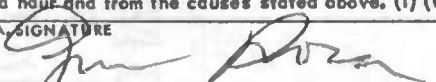
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

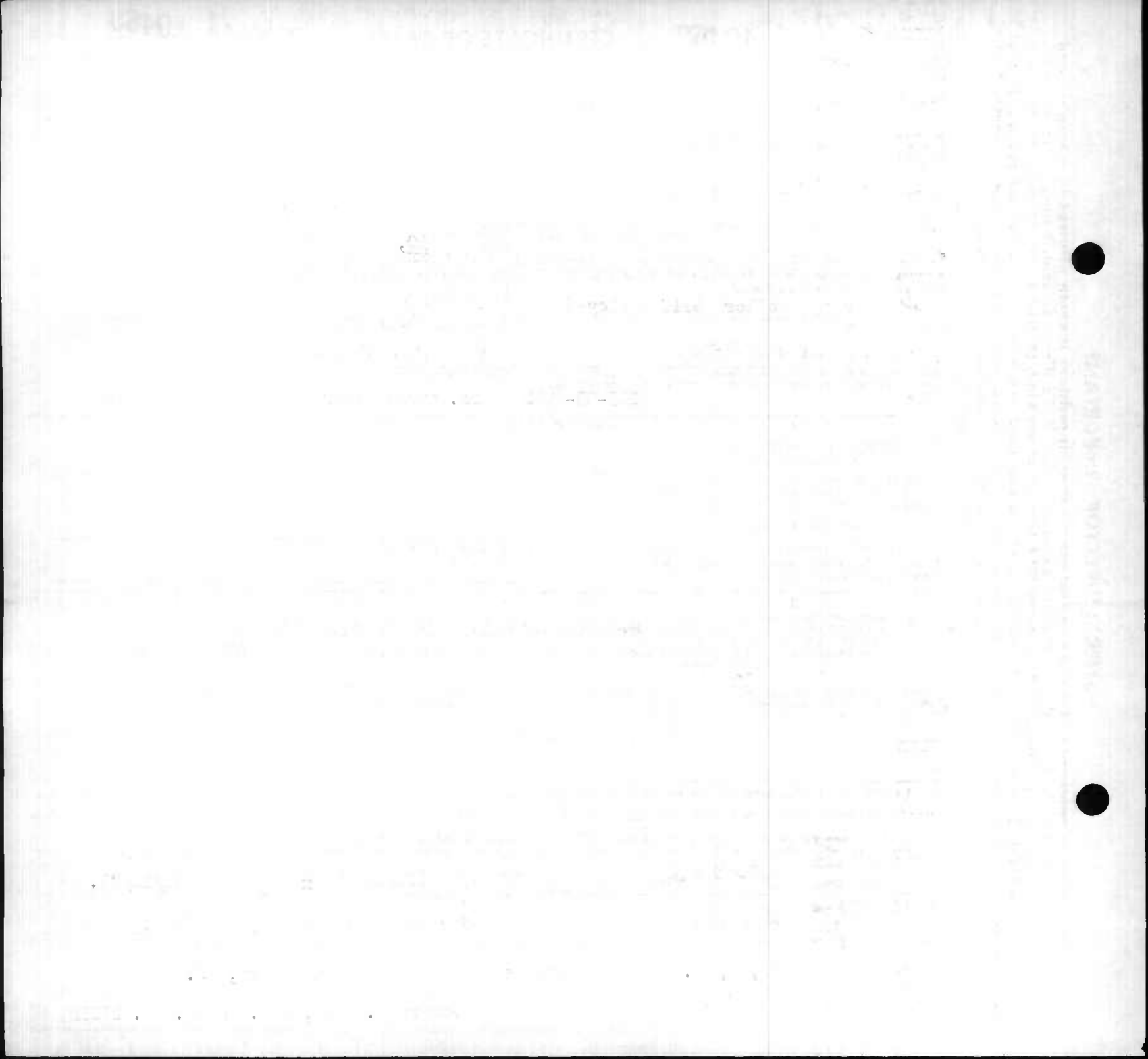
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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| U-352 71 10468                                                                                                                                                                                                                                                                                           |  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                 |  | REG. NO. 71 10468                                                                                                                                        |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                |  | 1. NAME OF DECEASED<br>(Type or Print)                                                   |  | 2. DATE AND HOUR OF DEATH                                                                                                                                |  |
|                                                                                                                                                                                                                                                                                                          |  | WHITTINGTON SALLY, ANNIE                                                                 |  | 11-5-71 6:40 P.M.                                                                                                                                        |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                   |  |                                                                                          |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                    |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                             |  |                                                                                          |  | A. STATE B. COUNTY                                                                                                                                       |  |
| 48 Maryland General Hosp. Separated                                                                                                                                                                                                                                                                      |  |                                                                                          |  | Md 1601                                                                                                                                                  |  |
| 5. SEX                                                                                                                                                                                                                                                                                                   |  | 6. RACE                                                                                  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| F                                                                                                                                                                                                                                                                                                        |  | N                                                                                        |  |                                                                                                                                                          |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                              |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |  | 8. DATE OF BIRTH                                                                                                                                         |  |
| Domestic                                                                                                                                                                                                                                                                                                 |  |                                                                                          |  | 5/1/1914                                                                                                                                                 |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                        |  | 14. MOTHER'S MAIDEN NAME                                                                 |  | 9. AGE (in years last birthday)                                                                                                                          |  |
| James Whittington                                                                                                                                                                                                                                                                                        |  | MARIA Hebron                                                                             |  | 37                                                                                                                                                       |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                 |  | 16. SOCIAL SECURITY NO.                                                                  |  | 11. BIRTHPLACE (State or foreign country)                                                                                                                |  |
| No                                                                                                                                                                                                                                                                                                       |  | R13-36-4137A                                                                             |  | USA - Md                                                                                                                                                 |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                       |  | 19. CAUSE OF DEATH                                                                       |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                             |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                             |  | Acute pulm. edema and congest. Stroke                                                    |  | USA                                                                                                                                                      |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                        |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                |  | Diabetes Mellitus                                                                        |  | Hours                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                          |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                      |  |                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                          |  | (C) _____                                                                                |  |                                                                                                                                                          |  |
| II                                                                                                                                                                                                                                                                                                       |  |                                                                                          |  |                                                                                                                                                          |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                         |  |                                                                                          |  |                                                                                                                                                          |  |
| Diabetes Mellitus                                                                                                                                                                                                                                                                                        |  |                                                                                          |  |                                                                                                                                                          |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                |  |
| 11/4/71                                                                                                                                                                                                                                                                                                  |  | Cataract                                                                                 |  |                                                                                                                                                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                    |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                 |  |
| No                                                                                                                                                                                                                                                                                                       |  | No                                                                                       |  |                                                                                                                                                          |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                            |  | 21E. INJURY OCCURRED                                                                     |  | 21F. HOW DID INJURY OCCUR?                                                                                                                               |  |
|                                                                                                                                                                                                                                                                                                          |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |                                                                                                                                                          |  |
| 22. I certify that (I) (this hospital) attended the deceased from 11/2 1971 to 11/5 1971 that (I) (we) last saw the deceased alive on 11/5 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                          |  |                                                                                                                                                          |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                           |  |                                                                                          |  | 23B. DATE SIGNED                                                                                                                                         |  |
| C. GAKUBA                                                                                                                                                                                                                                                                                                |  |                                                                                          |  | 11-5-71                                                                                                                                                  |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                             |  |                                                                                          |  | 23D. ADDRESS                                                                                                                                             |  |
| C. GAKUBA                                                                                                                                                                                                                                                                                                |  |                                                                                          |  | Maryland General Hosp.                                                                                                                                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                 |  | 24B. DATE                                                                                |  | 24C. NAME OF CEMETERY or CREMATORY                                                                                                                       |  |
| Burial                                                                                                                                                                                                                                                                                                   |  | 11-9-71                                                                                  |  | Brewer Hill                                                                                                                                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                          |  | 25B. NAME OF REGISTRAR                                                                   |  | 25C. FUNERAL DIRECTOR                                                                                                                                    |  |
| NOV 15 1971                                                                                                                                                                                                                                                                                              |  | Robert E. Sabers, M.D.                                                                   |  | C. E. Hicks, Jr.                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                          |  |                                                                                          |  | ADDRESS                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                          |  |                                                                                          |  | 1922 Forest Dr. ANNAPOLIS, Md                                                                                                                            |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| S-516                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 10469                                                                                                                                                       |  | BIRTH NO.                                                                                                 |  | CERTIFICATE OF DEATH                                                                                                                   |  | REG. NO. 71 10469                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN SAMPERY</b>                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |  |                                                                                                           |  | 2. DATE AND HOUR OF DEATH<br><b>11-11-71 10:37 P.M.</b>                                                                                |  |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |  |                                                                                                           |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>102</b> |  |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>MERCY HOSPITAL - BALTO. MD.</b>                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |  |                                                                                                           |  | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                    |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |  |                                                                                                           |  | E. STREET AND NUMBER<br><b>430 S. ROBINSON ST. 21224</b>                                                                               |  |                                                                                               |  |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                      | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>06-30-32</b>                                                                       |  | 9. AGE (In years last birthday)<br><b>39</b>                                                                                           |  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                                        |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED Tailor</b>                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Self Employed</b>                                                 |  | 11. BIRTHPLACE (State or foreign country)<br><b>ITALY</b>                                                                              |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>                                                     |  |
| 13. FATHER'S NAME<br><b>MARION SAMPERY</b>                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><b>ROSARIA DELASSANA</b>                                                      |  |                                                                                                                                        |  |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.<br><b>213-03-8952</b>                                                             |  | 17. INFORMANT<br><b>Mrs. Sarah Weber</b>                                                                                               |  | ADDRESS<br><b>(Same)</b>                                                                      |  |
| 18. <b>154.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CANCER OF RECTUM</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>ARTERIOSCLEROTIC HEART DISEASE</b> |                         |                                                                                                                                                             |  |                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                           |  |                                                                                               |  |
| 19A. DATE OF OPERATION<br><b>11-07-71</b>                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |  |                                                                                                           |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CA OF RECTUM</b>                                                                |  | 20A. AUTOPSY? (Yes or No)<br><b>-</b>                                                         |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |  |                                                                                                           |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                             |  |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1971</b> to <b>1971</b> that (I) (we) last saw the deceased alive on <b>11-11-71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                         |                         |                                                                                                                                                             |  |                                                                                                           |  |                                                                                                                                        |  |                                                                                               |  |
| 23A. SIGNATURE<br>                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |  |                                                                                                           |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>        |  | 23B. DATE SIGNED<br><b>11/11/71.</b>                                                          |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>G. Roca</b>                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |  |                                                                                                           |  | 23D. ADDRESS<br><b>MERCY HOSPITAL - BALTO. MD.</b>                                                                                     |  |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                  |                         | 24B. DATE<br><b>11/15/71</b>                                                                                                                                |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>                                       |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>                                                                 |  |                                                                                               |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 15 1971</b>                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Jaber, M.D.</b>                                                    |  | 25C. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>                                                                 |  |                                                                                               |  |

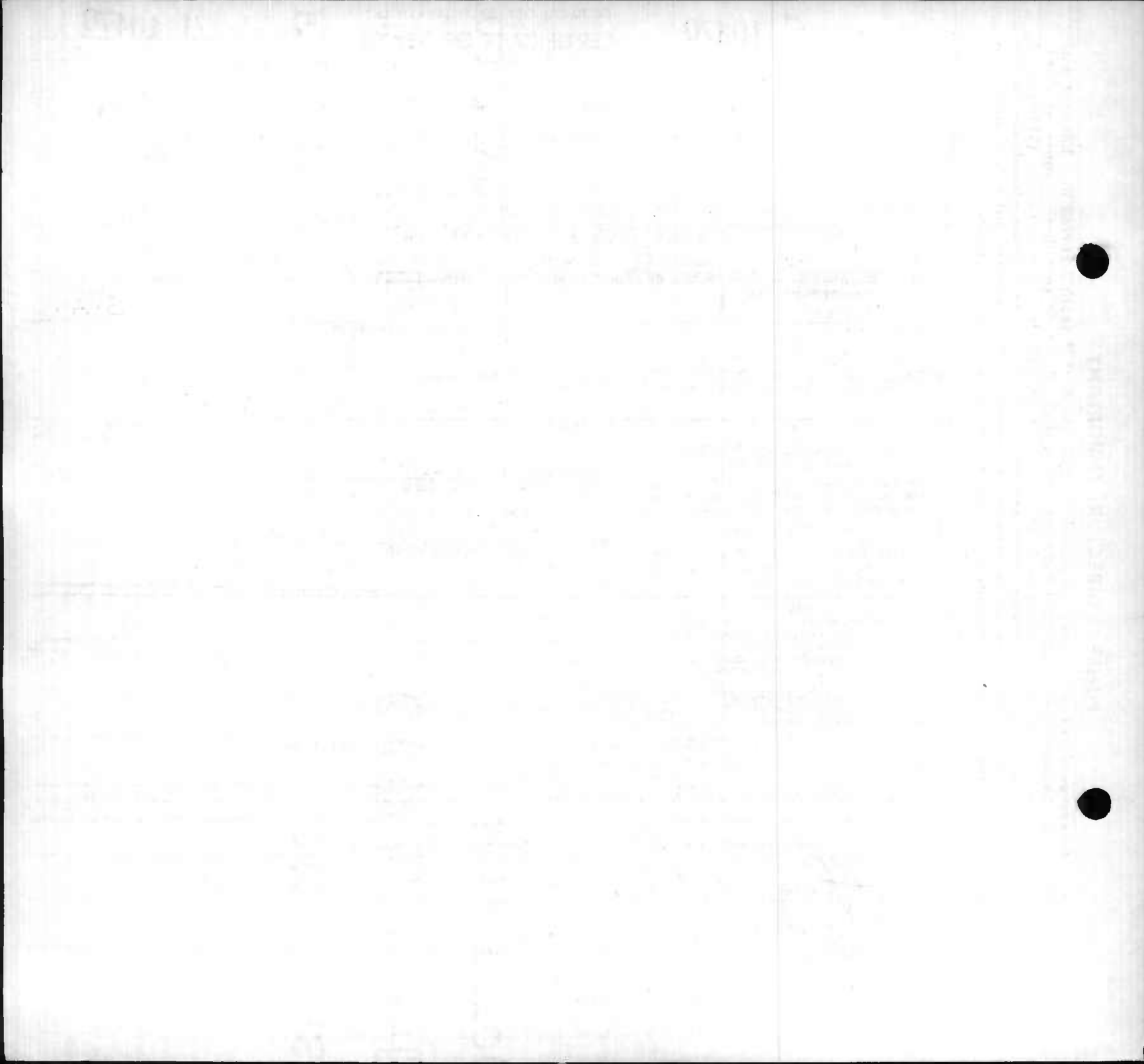




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

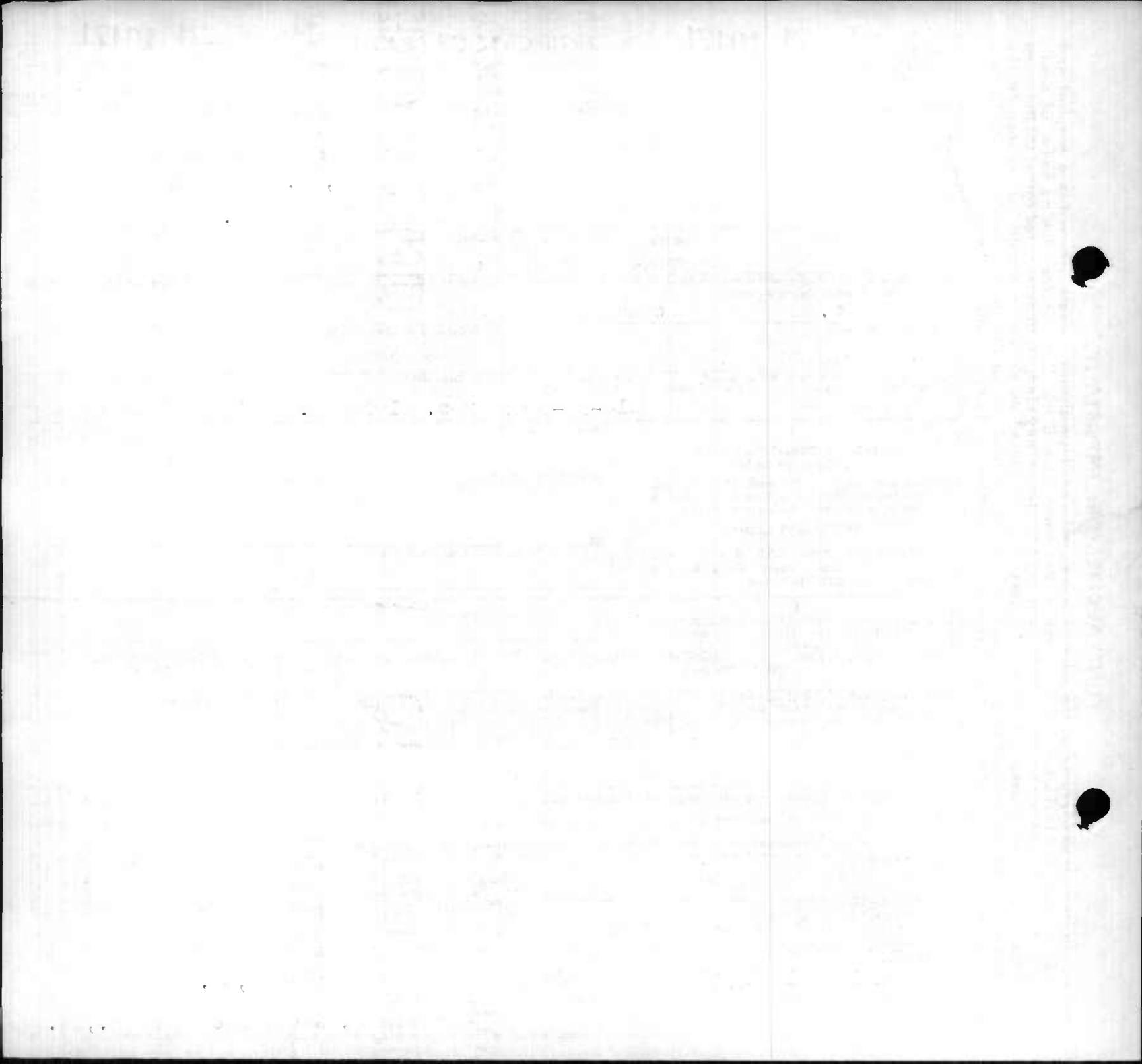
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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| U-160 71 10470                                                                                                                                                                                                                                                                                                                       |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                          |  | REG. NO. 71 10470                                                                                                                                           |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                            |  | 1. NAME OF DECEASED<br>(Type or Print) WEBER ESTELLE S.                                                                                                                                                                                   |  | 2. DATE AND HOUR OF DEATH<br>11-11-71 8 A. M.                                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                               |  | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)<br>A. STATE B. COUNTY<br>BALTIMORE MARYLAND 758                                                                                                      |  |                                                                                                                                                             |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>44 UNION MEMORIAL HOSPITAL                                                                                                                                                                                                                                                                   |  | C. CITY OR TOWN<br>BALTIMORE                                                                                                                                                                                                              |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                          |  |
| 5. SEX<br>F                                                                                                                                                                                                                                                                                                                          |  | 6. RACE<br>W                                                                                                                                                                                                                              |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br>1-6-95                                                                                                                                                                                                                                                                                                           |  | 9. AGE (In years last birthday)<br>76                                                                                                                                                                                                     |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>NONE                                                          |  |
| 11. BIRTHPLACE (State or foreign country)<br>MD                                                                                                                                                                                                                                                                                      |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                    |  |                                                                                                                                                             |  |
| 13. FATHER'S NAME<br>JACOB FUNK                                                                                                                                                                                                                                                                                                      |  | 14. MOTHER'S MAIDEN NAME<br>HELEN STEWART                                                                                                                                                                                                 |  |                                                                                                                                                             |  |
| 15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service)<br>NO                                                                                                                                                                                                                        |  | 16. SOCIAL SECURITY NO.<br>213-094638                                                                                                                                                                                                     |  | 17. INFORMANT<br>MR. J. ALBERT GREEN                                                                                                                        |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>CARDIORESPIRATORY IN SUFFICIENCY<br>- BRONCHOPNEUMONIA<br>(B) CARCINOMA OF STOMACH (DI)<br>DUE TO, OR AS A CONSEQUENCE OF:<br>SIMULATED AND METASTATIC<br>(C) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>24 hours.                                                                                                   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                           |  |                                                                                                                                                             |  |
| 19A. DATE OF OPERATION<br>11-22-71                                                                                                                                                                                                                                                                                                   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CA of STOMACH                                                                                                                                                                         |  | 20A. AUTOPSY? (Yes or No)<br>NO                                                                                                                             |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br>-                                                                                                                                                                                                                                           |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>-                                                                                                                                             |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>-                                                                               |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br>-                                                                                                                                                                                                                                                                    |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                 |  | 21F. HOW DID INJURY OCCUR?<br>-                                                                                                                             |  |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                  |  |                                                                                                                                                                                                                                           |  |                                                                                                                                                             |  |
| 23A. SIGNATURE<br>G. G. FINNEY JR. MD                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                           |  | 23B. DATE SIGNED                                                                                                                                            |  |
| 23C. PHYSICIAN'S NAME (Type)<br>G. G. FINNEY JR. MD                                                                                                                                                                                                                                                                                  |  | 23D. ADDRESS                                                                                                                                                                                                                              |  |                                                                                                                                                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                                                   |  | 24B. DATE<br>11-15-71                                                                                                                                                                                                                     |  | 24C. NAME OF CEMETERY OR CREMATORY<br>WESTERN CEMETERY                                                                                                      |  |
| 24D. LOCATION<br>BALTIMORE MD                                                                                                                                                                                                                                                                                                        |  | 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 15 1971                                                                                                                                                                                            |  |                                                                                                                                                             |  |
| 25B. NAME OF REGISTRAR<br>Robert E. Fisher, MD                                                                                                                                                                                                                                                                                       |  | 25C. FUNERAL DIRECTOR<br>LEONARD J. RUCK, BALTO, MD                                                                                                                                                                                       |  |                                                                                                                                                             |  |



# FUNERAL DIRECTOR: IMPORTANT

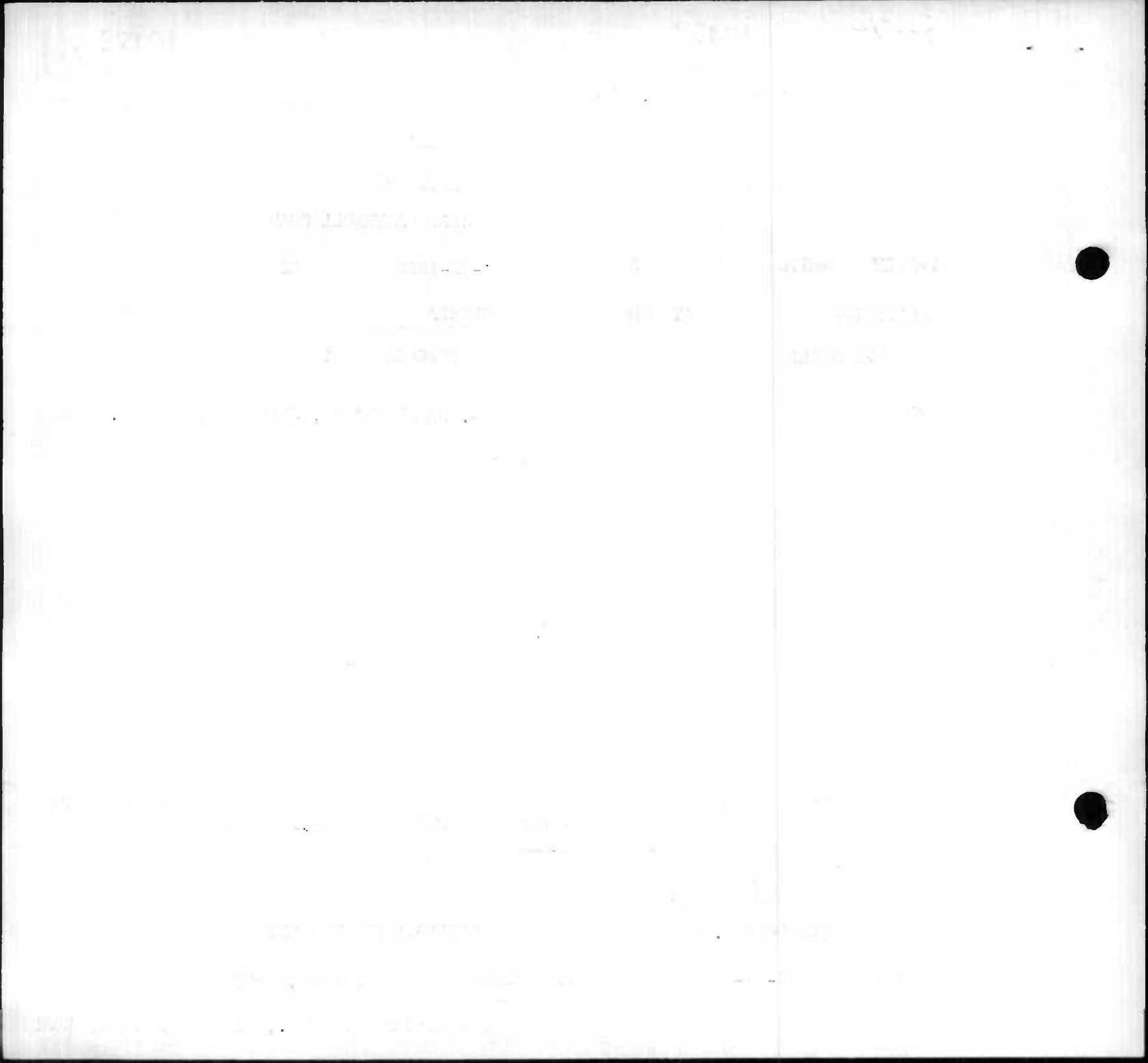
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                                                                                                                                                                                              |                                 | REG. NO. <u>71 10471</u>                                              |                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------------------------------------------------------|-------------------------------------------------------------|
| 7-420 71 10471                                                                                                                                                                                                                                                                                                                                        |                  | <b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                                  |                                 |                                                                       |                                                             |
| 1. NAME OF DECEASED<br>(Type or Print) <u>FOLISE, CARMELO</u>                                                                                                                                                                                                                                                                                         |                  | 2. DATE AND HOUR OF DEATH<br><u>11-10-71</u>   <u>6-05 AM.</u>                                                                                                                                                                                                                                                               |                                 |                                                                       |                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION <u>UMH</u><br><u>44</u>                                                                                                                                                                                                                            |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MD</u> B. COUNTY <u>BALTO.</u><br>C. CITY OR TOWN <u>Baltimore, Md.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>2822 Christopher Ave.</u> |                                 |                                                                       |                                                             |
| 5. SEX <u>M</u>                                                                                                                                                                                                                                                                                                                                       | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                  | 8. DATE OF BIRTH <u>4/21/82</u> | 9. AGE (In years last birthday) <u>89</u>                             | 10. Under 1 Yr. Months Days<br>11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>                                                                                                                                                                                                                                               |                  | 10B. KIND OF BUSINESS OR INDUSTRY <u>Ice man</u>                                                                                                                                                                                                                                                                             |                                 | 11. BIRTHPLACE (State or foreign country) <u>ITALY</u>                |                                                             |
| 12. CITIZEN OF WHAT COUNTRY? <u>YES</u>                                                                                                                                                                                                                                                                                                               |                  | 13. FATHER'S NAME <u>UNKNOWN</u>                                                                                                                                                                                                                                                                                             |                                 |                                                                       |                                                             |
| 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>                                                                                                                                                                                                                                                                                                               |                  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u> <u>NO</u>                                                                                                                                                                                            |                                 |                                                                       |                                                             |
| 16. SOCIAL SECURITY NO. <u>216-30-9067</u>                                                                                                                                                                                                                                                                                                            |                  | 17. INFORMANT ADDRESS<br><u>Mrs. Elvira M. Hanley</u> <u>Same as Above</u>                                                                                                                                                                                                                                                   |                                 |                                                                       |                                                             |
| 18. <u>436.9 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <u>CVA</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____                                                                                                                                                                             |                                 |                                                                       |                                                             |
| 19. DATE OF OPERATION <u>0</u>                                                                                                                                                                                                                                                                                                                        |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                             |                                 | 20A. AUTOPSY? (Yes or No)                                             |                                                             |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                  |                  | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                      |                                 |                                                                       |                                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                                                 |                  | 21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                     |                                 | 21C. HOW DID INJURY OCCUR?                                            |                                                             |
| 21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                              |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                       |                                 | 21F. HOW DID INJURY OCCUR?                                            |                                                             |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11/4/71</u> to <u>11/19/71</u> that (I) (we) last saw the deceased alive on <u>11-8</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.                       |                  |                                                                                                                                                                                                                                                                                                                              |                                 |                                                                       |                                                             |
| 23A. SIGNATURE <u>[Signature]</u>                                                                                                                                                                                                                                                                                                                     |                  | 23B. DATE SIGNED <u>11-10-71</u>                                                                                                                                                                                                                                                                                             |                                 | 23C. PHYSICIAN'S NAME (Type) <u>G. NAHAS.</u>                         |                                                             |
| 23D. ADDRESS <u>UMH</u>                                                                                                                                                                                                                                                                                                                               |                  | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                                                                                                                                                                                       |                                 |                                                                       |                                                             |
| 24B. DATE <u>11/13/71</u>                                                                                                                                                                                                                                                                                                                             |                  | 24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer</u>                                                                                                                                                                                                                                                                      |                                 | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>   |                                                             |
| 25A. DATE REC'D BY HEALTH DEPT. <u>NOV 15 1971</u>                                                                                                                                                                                                                                                                                                    |                  | 25B. NAME OF REGISTRAR <u>[Signature]</u>                                                                                                                                                                                                                                                                                    |                                 | 25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc Balto., Md.</u> |                                                             |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                             |                                                                                                                                                                                                                                                                                                                             |                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| <p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                             | <p>REG. NO. <b>71 10472</b></p>                                                                                                                                                                                                                                                                                             |                                          |
| <p><b>S-514 71 10472</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                             |                                                                                                                                                                                                                                                                                                                             |                                          |
| <p><b>BIRTH NO.</b></p> <p>1. NAME OF DECEASED (Type or Print) <b>SILANFELD, LIBBY</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                             | <p>2. DATE AND HOUR OF DEATH</p> <p><b>11-10-71 12 Noon</b></p>                                                                                                                                                                                                                                                             |                                          |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><b>91 LEVINDALE</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                  |                             | <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>4535 MARYKNOLL ROAD</b></p> |                                          |
| <p>5. SEX <b>FEMALE</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <p>6. RACE <b>WHITE</b></p> | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>                                                                                                                                                             | <p>8. DATE OF BIRTH <b>4-25-1889</b></p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><b>HOUSEWIFE</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                             | <p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p><b>AT HOME</b></p>                                                                                                                                                                                                                                                              |                                          |
| <p>11. BIRTHPLACE (State or foreign country)</p> <p><b>RUSSIA</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                             | <p>12. CITIZEN OF WHAT COUNTRY?</p> <p><b>USA</b></p>                                                                                                                                                                                                                                                                       |                                          |
| <p>13. FATHER'S NAME</p> <p><b>EMANUEL SMALL</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                             | <p>14. MOTHER'S MAIDEN NAME</p> <p><b>REBECCA ?</b></p>                                                                                                                                                                                                                                                                     |                                          |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><b>NO</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                             | <p>16. SOCIAL SECURITY NO.</p>                                                                                                                                                                                                                                                                                              |                                          |
| <p>17. INFORMANT</p> <p><b>MRS. HARRY FRADIN, 4535 MARYKNOLL RD. #21208</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                             | <p>ADDRESS</p>                                                                                                                                                                                                                                                                                                              |                                          |
| <p>18. <b>412.3 I</b> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>ARTERIOSCLEROTIC HEART DISEASE</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b></p> |                             |                                                                                                                                                                                                                                                                                                                             |                                          |
| <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             |                                                                                                                                                                                                                                                                                                                             |                                          |
| <p>19A. DATE OF OPERATION <b>2</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                             | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>                                                                                                                                                                                                                                                                     |                                          |
| <p>20A. AUTOPSY? (Yes or No) <b>NO</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                             | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>                                                                                                                                                                                                                                                 |                                          |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                             | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>                                                                                                                                                                                                                             |                                          |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                             | <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>                                                                                                                                                                                                                                                            |                                          |
| <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             | <p>21F. HOW DID INJURY OCCUR?</p>                                                                                                                                                                                                                                                                                           |                                          |
| <p>22. I certify that (H) (this hospital) attended the deceased from <b>11-10-71</b> to <b>11-10-71</b> that (H) (we) last saw the deceased alive on <b>11-10-71</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did not) view the body after death.</p>                                                                                                                                                                                                                                                                                                     |                             |                                                                                                                                                                                                                                                                                                                             |                                          |
| <p>23A. SIGNATURE</p> <p><i>Theodore R. Reiss</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                             | <p>23B. DATE SIGNED</p>                                                                                                                                                                                                                                                                                                     |                                          |
| <p>23C. PHYSICIAN'S NAME (Type)</p> <p><b>THEODORE R. REISS</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                             | <p>23D. ADDRESS</p> <p><b>LEVINDALE HEBREW HOME</b></p>                                                                                                                                                                                                                                                                     |                                          |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p><b>BURIAL</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                             | <p>24B. DATE</p> <p><b>11-11-71</b></p>                                                                                                                                                                                                                                                                                     |                                          |
| <p>24C. NAME of CEMETERY or CREMATORY</p> <p><b>TIFEREETH ISRAEL ANSHE SFARD</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                             | <p>24D. LOCATION (City, town, or county) (State)</p> <p><b>ROSEDALE, MARYLAND</b></p>                                                                                                                                                                                                                                       |                                          |
| <p>25A. DATE REC'D BY HEALTH DEPT.</p> <p><b>NOV 15 1971 Robert E. Farber, M.D.</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             | <p>25B. NAME OF REGISTRAR</p>                                                                                                                                                                                                                                                                                               |                                          |
| <p>25C. FUNERAL DIRECTOR</p> <p><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             | <p>ADDRESS</p>                                                                                                                                                                                                                                                                                                              |                                          |



FUNERAL DIRECTOR: IMPORTANT  
THE MEDICAL EXAMINER'S OFFICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                                                                                                            |                                                                                  |                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| G-610<br>BIRTH NO. 71 10473                                                                                                                                                                                                                                                                                                                                 |                         | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                    |                                                                                                                                            | REG. NO. 71 10473                                                                |                                                                                                             |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Steven B. Greif</b>                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>Nov. 9, 1971 3:30 P. M.</b>                                                                                |                                                                                  |                                                                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2798</b> |                                                                                  |                                                                                                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>THE JOHNS HOPKINS HOSPITAL</b><br><b>33 BALTIMORE, MD 21205</b>                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                        |                                                                                  | D. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |
| E. STREET AND NUMBER<br><b>3508 SPAULDING AVE</b>                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                                                                                                                            |                                                                                  |                                                                                                             |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                       | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>04-19-50</b>                                                                                                        | 9. AGE (In years last birthday)<br><b>21</b>                                     | If Under 1 Yr. Months: Days: Hours: Min.                                                                    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NONE</b>                                                                                                                                                                                                                                                  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>                                                                                                            |                                                                                                                                            | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MARYLAND</b>          |                                                                                                             |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                                                                                                                            |                                                                                  |                                                                                                             |
| 13. FATHER'S NAME<br><b>SAMUEL <del>JOHNS</del> GREIF</b>                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>BETTY <del>FRIDEN</del> PRIBESH</b>                                                                         |                                                                                  |                                                                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>NO</b>                                                                                                       |                                                                                  |                                                                                                             |
| 17. INFORMANT<br><b>MRS. BETTY GREIF, 3508 SPAULDING AVE. #21215</b>                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             | ADDRESS                                                                                                                                    |                                                                                  |                                                                                                             |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br><b>Hypo Kalemia + Dehydration</b><br><b>3 days</b>                                                                           |                         |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b>                                                                              |                                                                                  |                                                                                                             |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Renal Concentrating defect</b><br><b>Unknown</b>                                                                                                                                                                       |                         |                                                                                                                                                             |                                                                                                                                            |                                                                                  |                                                                                                             |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Cerebral palsy &amp; Scoliosis</b><br><b>21 years</b>                                                                                                                                                                |                         |                                                                                                                                                             |                                                                                                                                            |                                                                                  |                                                                                                             |
| 19A. DATE OF OPERATION<br><b>9-16-71</b>                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Scoliosis</b>                                                                       |                                                                                  | 20A. AUTOPSY (Yes or No)<br><b>Yes</b>                                                                      |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>No</b>                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                                                                                                                            |                                                                                  |                                                                                                             |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nearly medical examined)                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                   |                                                                                  |                                                                                                             |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                                                                                                                            |                                                                                  |                                                                                                             |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                  |                                                                                  |                                                                                                             |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                                                                                                                            |                                                                                  |                                                                                                             |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9-14</b> 19 <b>71</b> to <b>11-9</b> 19 <b>71</b><br>that (I) (we) last saw the deceased alive on <b>Nov 9</b> , 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                                                                                                                            |                                                                                  |                                                                                                             |
| 23A. SIGNATURE<br><b>David S. Hungerford, MD</b>                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             | 23B. DATE SIGNED<br><b>Nov. 9, 1971</b>                                                                                                    |                                                                                  |                                                                                                             |
| 23C. PHYSICIAN'S NAME (Type)<br><b>DAVID S. HUNGERFORD M.D.</b>                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             | 23D. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL</b>                                                                                          |                                                                                  |                                                                                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                   |                         | 24B. DATE<br><b>11-11-71</b>                                                                                                                                |                                                                                                                                            | 24C. NAME OF CEMETERY OR CREMATORY<br><b>BETH TFILOH</b>                         |                                                                                                             |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE, MARYLAND</b>                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                                                                                                                            |                                                                                  |                                                                                                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 15 1971</b>                                                                                                                                                                                                                                                                                                       |                         | 25B. NAME OF REGISTRAR<br><b>Robert J. ...</b>                                                                                                              |                                                                                                                                            | 25C. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b> |                                                                                                             |

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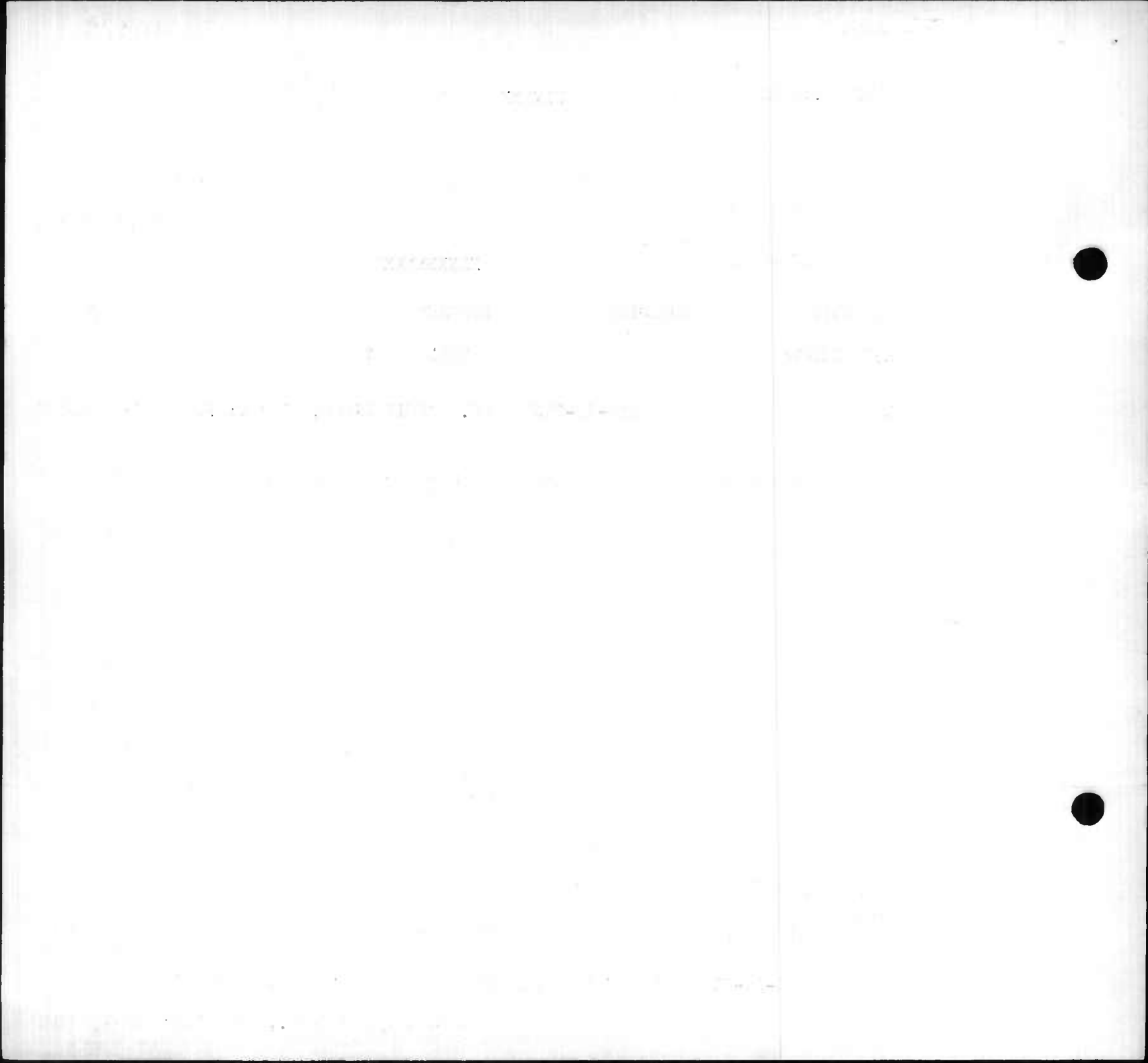
STUDY



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

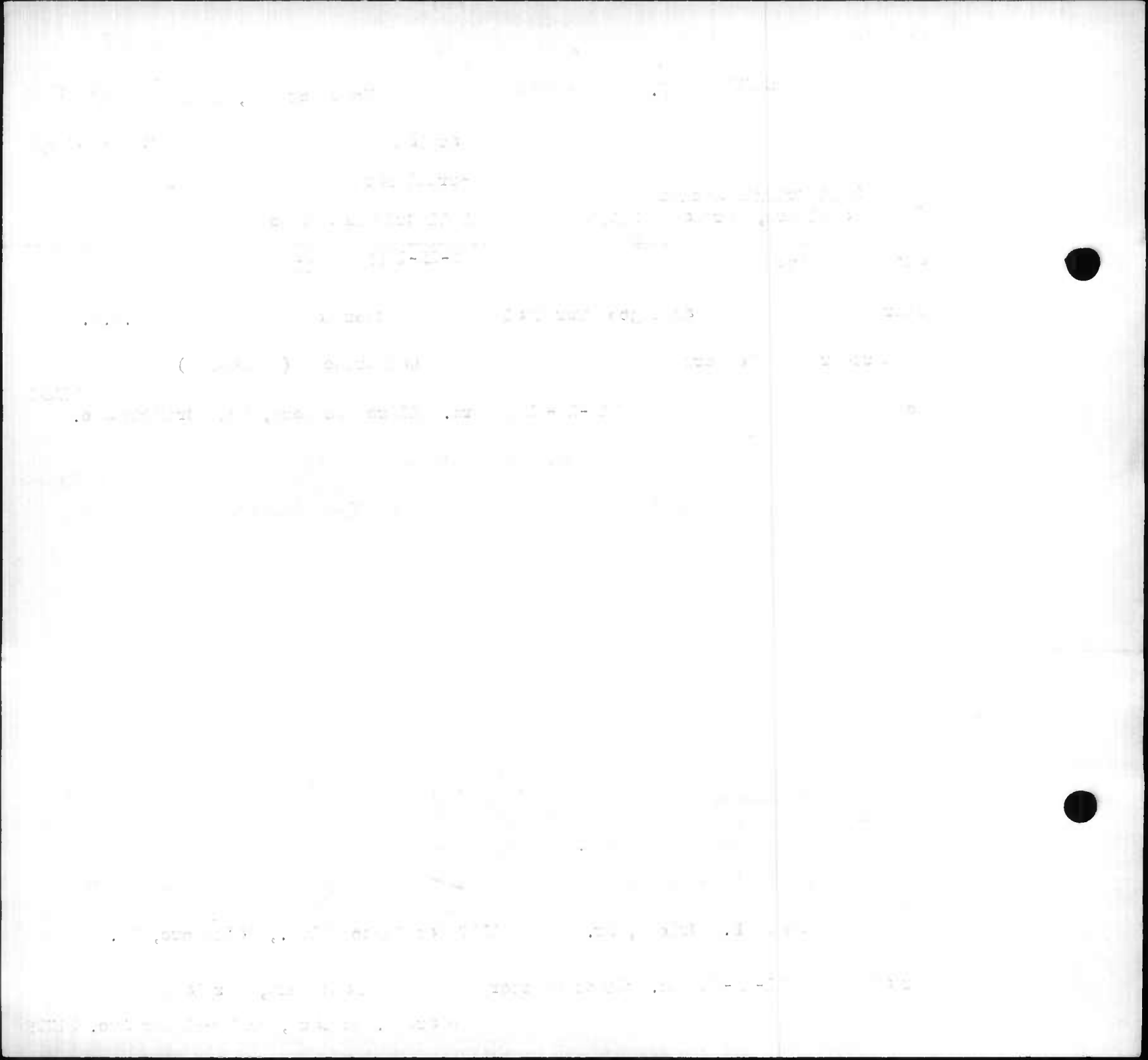
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                  |                      |                                                                                                                                                             |  | 71 10474                                                                                                                                                    |                                       | REG. NO. 71 10474                                                                             |                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------|
| Z-200 71 10474                                                                                                                                                                                                                                                                                                                                                    |                      |                                                                                                                                                             |  | CERTIFICATE OF DEATH                                                                                                                                        |                                       |                                                                                               |                             |
| 1. NAME OF DECEASED<br>(Type or Print) <del>XXXXXXXXXX</del> MORRIS XISSON ZISOW                                                                                                                                                                                                                                                                                  |                      |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br>11/9/71 11:45 A.M.                                                                                                             |                                       |                                                                                               |                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>SINAI HOSPITAL OF BALTIMORE                                                                                                                                                            |                      |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE MD B. COUNTY BALTO. 2720                                  |                                       |                                                                                               |                             |
|                                                                                                                                                                                                                                                                                                                                                                   |                      |                                                                                                                                                             |  | C. CITY OR TOWN<br>BALTO                                                                                                                                    |                                       | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                             |
|                                                                                                                                                                                                                                                                                                                                                                   |                      |                                                                                                                                                             |  | E. STREET AND NUMBER<br>3741 CLARINTH RD #15                                                                                                                |                                       |                                                                                               |                             |
| 5. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                    | 6. RACE<br>CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>5/13/1911                                                                                                                               | 9. AGE (in years last birthday)<br>53 | If Under 1 Yr. Months Days                                                                    | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>CARPENTER                                                                                                                                                                                                                                                          |                      | 10B. KIND OF BUSINESS OR INDUSTRY<br>BUILDING                                                                                                               |  | 11. BIRTHPLACE (State or foreign country)<br>HUNGARY                                                                                                        |                                       | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                           |                             |
| 13. FATHER'S NAME<br>DAVID ZISOW                                                                                                                                                                                                                                                                                                                                  |                      |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br>UDEL ?                                                                                                                          |                                       |                                                                                               |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO                                                                                                                                                                                                                                                    |                      | 16. SOCIAL SECURITY NO.<br>219-42-7650                                                                                                                      |  | 17. INFORMANT ADDRESS<br>MRS. MARGIT ZISOW, 3741 CLARINTH ROAD #21215                                                                                       |                                       |                                                                                               |                             |
| 18. 573.91 CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                      |                                                                                                                                                             |  | (A) IMMEDIATE CAUSE<br>HEPATIC COMA<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) HEPATIC INSUFFICIENCY<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>24 HRS<br>2 YEARS                             |                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                            |                      |                                                                                                                                                             |  |                                                                                                                                                             |                                       |                                                                                               |                             |
| 19A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                                                       |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                   |                                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                             |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |                                       |                                                                                               |                             |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                         |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |                                       |                                                                                               |                             |
| 22. I certify that (I) (this hospital) attended the deceased from 11/1/71 to 11/9/71 that (I) (we) last saw the deceased alive on 11/9/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                |                      |                                                                                                                                                             |  |                                                                                                                                                             |                                       |                                                                                               |                             |
| 23A. SIGNATURE<br>D. GRASER, M.D.                                                                                                                                                                                                                                                                                                                                 |                      |                                                                                                                                                             |  | 23B. DATE SIGNED                                                                                                                                            |                                       | 23C. PHYSICIAN'S NAME (Type)<br>D. GRASER, M.D.                                               |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                                                                                |                      | 24B. DATE<br>11-10-71                                                                                                                                       |  | 24C. NAME OF CEMETERY or CREMATORY<br>BETH ISAAC ADATH ISRAEL                                                                                               |                                       | 24D. LOCATION (City, town, or county) (State)<br>BALTIMORE, MARYLAND                          |                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 15 1971 Robert E. Farber, M.D.                                                                                                                                                                                                                                                                                             |                      | 25B. NAME OF REGISTRAR                                                                                                                                      |  | 25C. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD                                                                                       |                                       | ADDRESS                                                                                       |                             |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| R-326 71 10475                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                    |                               | REG. NO. 71 10475                                                        |                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  | 1. NAME OF DECEASED<br>(Type or Print) HENRY J. RODGERS                                                                                                     |                               | 2. DATE AND HOUR OF DEATH<br>November 10, 1971 11 P. M.                  |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE Maryland<br>B. COUNTY 2553                                 |                               | C. CITY OR TOWN Morrell Park                                             |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>00 2011 Griffis Avenue<br>Baltimore, Maryland 21230                                                                                                                                                                                                                                                                                                                              |                  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                               |                               | E. STREET AND NUMBER<br>2011 Griffis Avenue                              |                                                           |
| 5. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>3-15-1899 | 9. AGE (In years last birthday)<br>72                                    | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Clerk                                                                                                                                                                                                                                                                                                                                                                                          |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Washington Terminal                                                                                                    |                               | 11. BIRTHPLACE (State or foreign country)<br>Georgia                     |                                                           |
| 13. FATHER'S NAME<br>Arthur Rodgers                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  | 14. MOTHER'S MAIDEN NAME<br>Catherine (Unknown)                                                                                                             |                               | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                   |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                                                                                                |                  | 16. SOCIAL SECURITY NO.<br>718-18-0299                                                                                                                      |                               | 17. INFORMANT ADDRESS<br>Mrs. Mildred Rodgers, 2011 Griffis Ave. 21230   |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>Carcinoma, Prostate<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: metastasis<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 1/2 years                                                                                                 |                               |                                                                          |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                             |                               |                                                                          |                                                           |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                               | 20A. AUTOPSY? (Yes or No)                                                |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                               | 21F. HOW DID INJURY OCCUR?                                               |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from 11/9/71 to 11/10/71 that (I) (we) last saw the deceased alive on 11/9/71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                              |                  |                                                                                                                                                             |                               |                                                                          |                                                           |
| 23A. SIGNATURE<br>John P. Urlock, Jr.                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 23B. DATE SIGNED<br>11/11/71                                                                                                                                |                               | 23C. PHYSICIAN'S NAME (Type)<br>John P. Urlock, Jr.                      |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 24B. DATE<br>11-15-71                                                                                                                                       |                               | 24C. NAME OF CEMETERY or CREMATORY<br>Mt. Olivet Cemetery                |                                                           |
| 24D. LOCATION<br>Baltimore, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  | 24E. NAME OF REGISTRAR<br>Robert E. Fisher, Jr.                                                                                                             |                               | 24F. FUNERAL DIRECTOR<br>Howard H. Hubbard, 4107 Wilkens Ave. 21229      |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 15 1971                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | 25B. NAME OF REGISTRAR                                                                                                                                      |                               | 25C. FUNERAL DIRECTOR                                                    |                                                           |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 71-16154

REG. NO. 10476

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Kimberly Ball</b>                                                                                                                                                                                                                                                                                                                                                   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month <b>11</b> Day <b>9</b> Year <b>71</b><br>Estimated <input type="checkbox"/> Hour <b>9:35A.</b> M.           |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Hospitals</b>                                                                                                                                                                                                                                                                             |  | 3. DATE PRONOUNCED DEAD<br>Month <b>11</b> Day <b>9</b> Year <b>71</b> Hour <b>9:35 A.</b> M.                                                                                   |  |
| 6. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 7. RACE<br><b>White</b>                                                                                                                                                         |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                   |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>                                    |  |
| 9. DATE OF BIRTH<br><b>9-21-71</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 10. AGE (In years last birthday)<br><b>1</b> 18                                                                                                                                 |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                   |  |
| 13. FATHER'S NAME<br><b>Timothy L. Ball</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 14. MOTHER'S MAIDEN NAME<br><b>Claudia A. Hickey</b>                                                                                                                            |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                       |  | 16. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                                                          |  |
| 17. INFORMANT<br><b>Father: Mr. Timothy L. Ball</b>                                                                                                                                                                                                                                                                                                                                                           |  | 18. ADDRESS<br><b>1611 Inverness Ave. Dundalk, Md. 21222</b>                                                                                                                    |  |
| 19. <b>795X1</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | CAUSE OF DEATH                                                                                                                                                                  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                |  | (A) IMMEDIATE CAUSE SDII<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                     |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                             |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                              |  | (C)                                                                                                                                                                             |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                          |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                        |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                      |  | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                 |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                        |  | 22F. HOW DID INJURY OCCUR?                                                                                                                                                      |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                                                                 |  |
| ACTUAL SIGNATURE OF EXAMINER'S NAME (Type)<br><b>Werner U. Spitz, M.D.</b>                                                                                                                                                                                                                                                                                                                                    |  | Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| DATE SIGNED<br><b>11-9-71</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                     |  | 24B. DATE<br><b>11-12-71</b>                                                                                                                                                    |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Cedar Hill Cemetery</b>                                                                                                                                                                                                                                                                                                                                              |  | 24D. LOCATION (City, town, or county) (State)<br><b>Glen Burnie, Maryland</b>                                                                                                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 15 1971</b>                                                                                                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>                                                                                                                         |  |
| 25C. FUNERAL DIRECTOR<br><b>John J. Duda</b>                                                                                                                                                                                                                                                                                                                                                                  |  | ADDRESS<br><b>7922 Wise Ave. Dundalk, Md.</b>                                                                                                                                   |  |

10476

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                         |                                                                                                                                                             |                                                                                                                                                                                                           | REG. NO. <span style="font-size: 1.5em;">71 10477</span>                                                              |                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">H-10071 10477</span> <span style="font-size: 1.5em;">BIRTH NO. 71-17783</span> </div>                                                                                                                                                                                                                                                                                                                                |                                                         |                                                                                                                                                             |                                                                                                                                                                                                           |                                                                                                                       |                                                                                                                                             |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">Hauf, Thomas E.</span>                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.2em;">11-10-71</span> <span style="float: right;">11:25 AM M.</span>                                                                               |                                                                                                                       |                                                                                                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Howard</span> |                                                                                                                       |                                                                                                                                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><span style="font-size: 1.5em;">37</span> <span style="font-size: 1.2em;">Mercy Hospital, Inc.</span>                                                                                                                                                                                                                                                                                                                                                                     |                                                         |                                                                                                                                                             | C. CITY OR TOWN <span style="font-size: 1.2em;">Ellicott City</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                           |                                                                                                                       |                                                                                                                                             |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                         |                                                                                                                                                             | E. STREET AND NUMBER<br><span style="font-size: 1.2em;">9810 Gwynn Pk Dr</span>                                                                                                                           |                                                                                                                       |                                                                                                                                             |
| 5. SEX<br><span style="font-size: 1.2em;">Male</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 6. RACE<br><span style="font-size: 1.2em;">White</span> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><span style="font-size: 1.2em;">10-8-71</span>                                                                                                                                        | 9. AGE (In years last birthday)<br><span style="font-size: 1.2em;">11</span> <span style="font-size: 1.2em;">2</span> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">Infant</span> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                         |                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">Maryland</span>                                                                                                              |                                                                                                                       |                                                                                                                                             |
| 10B. KIND OF BUSINESS OR INDUSTRY<br><span style="font-size: 1.2em;">none</span>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                         |                                                                                                                                                             | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">USA</span>                                                                                                                                |                                                                                                                       |                                                                                                                                             |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">Diane Breeden</span>                                                                                                                          |                                                                                                                       |                                                                                                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">No</span>                                                                                                                                                                                                                                                                                                                                                             |                                                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.2em;">None</span>                                                                                                                                    |                                                                                                                       |                                                                                                                                             |
| 17. INFORMANT<br><span style="font-size: 1.2em;">Earl S. Breeden, Jr.</span>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                         |                                                                                                                                                             | ADDRESS<br><span style="font-size: 1.2em;">Same</span>                                                                                                                                                    |                                                                                                                       |                                                                                                                                             |
| 18. <span style="font-size: 1.5em;">743.01</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><span style="font-size: 1.2em;">Respiratory Arrest</span><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><span style="font-size: 1.2em;">Aspiration pneumonia</span> |                                                         |                                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><span style="font-size: 1.2em;">Encephalocele</span>                                                                      |                                                                                                                       |                                                                                                                                             |
| 19. DATE OF OPERATION<br><span style="font-size: 1.2em;">10-22-71</span>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                         |                                                                                                                                                             | 19A. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><span style="font-size: 1.2em;">Encephalocele</span>                                                                                                  |                                                                                                                       |                                                                                                                                             |
| 20A. AUTOPSY? (Yes or No)<br><span style="font-size: 1.2em;">No</span>                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                         |                                                                                                                                                             | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                      |                                                                                                                       |                                                                                                                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                 |                                                         |                                                                                                                                                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                                                                   |                                                                                                                       |                                                                                                                                             |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                         |                                                                                                                                                             | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><span style="font-size: 1.2em;">10-8</span>                                                                                                            |                                                                                                                       |                                                                                                                                             |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                         |                                                         |                                                                                                                                                             | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                |                                                                                                                       |                                                                                                                                             |
| 22. I certify that (A) (this hospital) attended the deceased from <span style="font-size: 1.2em;">11-10-71</span> to <span style="font-size: 1.2em;">11-10-71</span> and that (B) (we) last saw the deceased alive on <span style="font-size: 1.2em;">11-10-71</span> and that (C) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                         |                                                         |                                                                                                                                                             |                                                                                                                                                                                                           |                                                                                                                       |                                                                                                                                             |
| 23A. SIGNATURE<br><span style="font-size: 1.5em;">Emmanuel N. Macaraeg, M.D.</span>                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                         |                                                                                                                                                             | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">11-10-71</span>                                                                                                                                       |                                                                                                                       |                                                                                                                                             |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">EMMANUEL N. MACARAEG, M.D.</span>                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                         |                                                                                                                                                             | 23D. ADDRESS<br><span style="font-size: 1.2em;">Mercy Hospital, 301 St. Paul St. #21202</span>                                                                                                            |                                                                                                                       |                                                                                                                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">Burial</span>                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                         |                                                                                                                                                             | 24B. DATE<br><span style="font-size: 1.2em;">11/11/71</span>                                                                                                                                              |                                                                                                                       |                                                                                                                                             |
| 24C. NAME OF CEMETERY or CREMATORY<br><span style="font-size: 1.2em;">Mt. Olive</span>                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                         |                                                                                                                                                             | 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">Mt. Airey, Maryland</span>                                                                                               |                                                                                                                       |                                                                                                                                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.5em;">NOV 15 1971</span>                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                         |                                                                                                                                                             | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">Edw. S. MacNabb Sons, Inc. 301 Frederick Rd. Catonsville, Md. 21228</span>                                                                      |                                                                                                                       |                                                                                                                                             |



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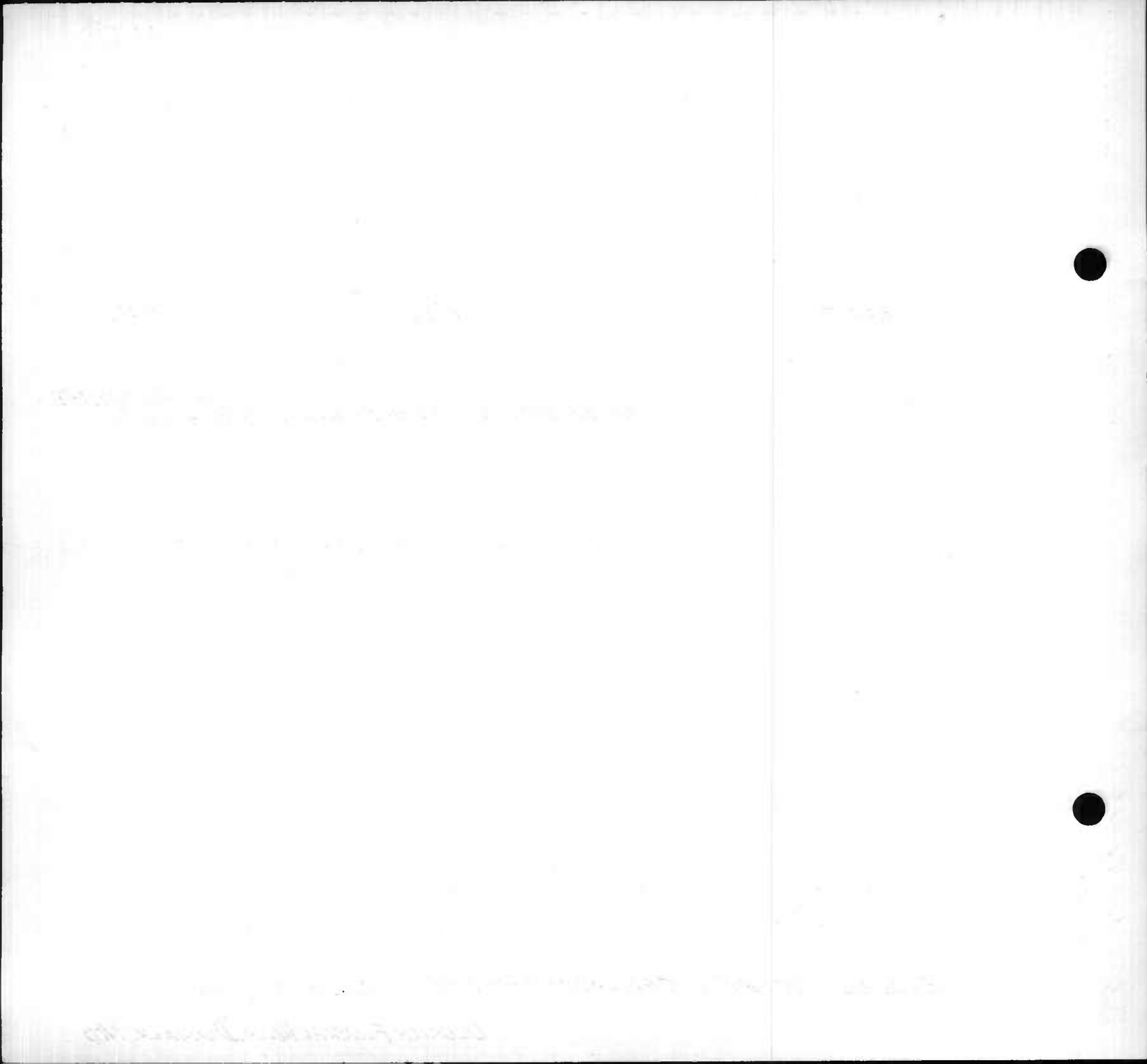
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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

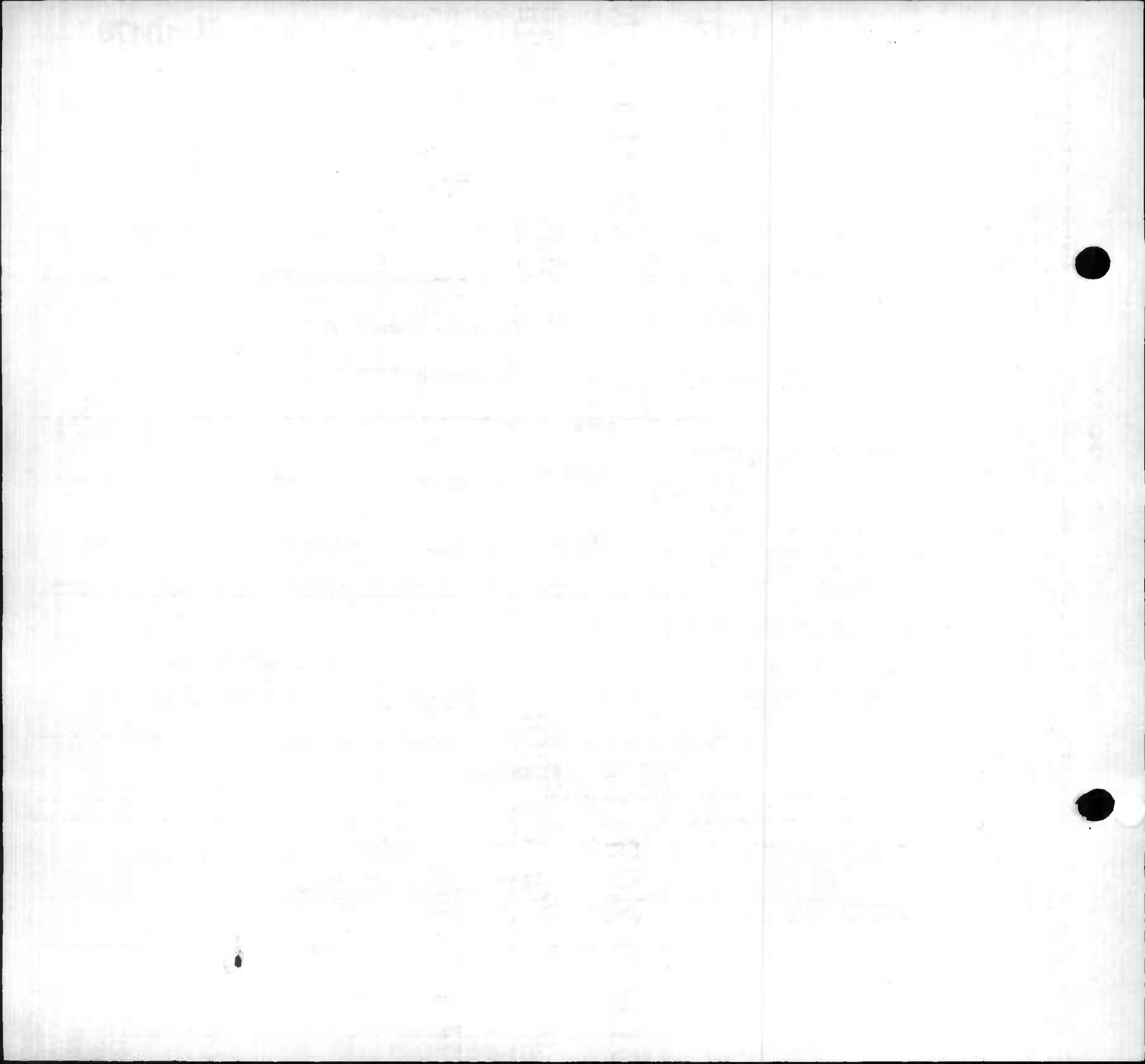
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | CERTIFICATE OF DEATH                                                                                                                                     |  | REG. NO. 71 10478                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|--|
| BIRTH NO. H-200                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | 71 10478                                                                                                                                                 |  |                                                                                 |  |
| 1. NAME OF DECEASED (Type or Print) HOUSE, Jeanette                                                                                                                                                                                                                                                           |  |                                                                                                        |  | 2. DATE AND HOUR OF DEATH 11/11/71 4:27 a.m.                                                                                                             |  |                                                                                 |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                        |  |                                                                                                        |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                    |  |                                                                                 |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital                                                                                                                                                                       |  |                                                                                                        |  | A. STATE Maryland B. COUNTY Anne Arundle 5210                                                                                                            |  |                                                                                 |  |
|                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | C. CITY OR TOWN Annapolis                                                                                                                                |  | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | E. STREET AND NUMBER 1270 Pinehill Drive                                                                                                                 |  |                                                                                 |  |
| 5. SEX Female                                                                                                                                                                                                                                                                                                 |  | 6. RACE Cauc.                                                                                          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH 7/8/13                                                         |  |
|                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | 9. AGE (In years last birthday) 58                                                                                                                       |  | 10. Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min.                         |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWP                                                                                                                                                                                                              |  |                                                                                                        |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                        |  | 11. BIRTHPLACE (State or foreign country) MD                                    |  |
| 13. FATHER'S NAME John Kirckhoff                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | 14. MOTHER'S MAIDEN NAME Minnie Ault                                                                                                                     |  |                                                                                 |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO                                                                                                                                                                                                   |  |                                                                                                        |  | 16. SOCIAL SECURITY NO. 214-38-3291                                                                                                                      |  | 17. INFORMANT ADDRESS Mrs. Edith Becker, 1270 Pine Hill Dr.                     |  |
| 18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH PROBABLE M.I.                                                                                                                                                                                                                                      |  |                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |  |                                                                                 |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                  |  |                                                                                                        |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                                                      |  |                                                                                 |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  | (B) DISSEMINATED AORTOARTERIOSCLEROSIS S.M.D.                                                                                                            |  |                                                                                 |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                     |  |                                                                                                        |  | (C)                                                                                                                                                      |  |                                                                                 |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                 |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                        |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20A. AUTOPSY? (Yes or No) NO                                                                                                                             |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?            |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                 |  |                                                                                 |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                     |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                                               |  |                                                                                 |  |
| 22. I certify that (I) (the hospital) attended the deceased from 11/10 19 71 to 11/10 19 71 that (I) (we) last saw the deceased alive on 11/10 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                 |  |
| 23A. SIGNATURE David S. Zee M.D.                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | 23B. DATE SIGNED 11/11/71                                                                                                                                |  |                                                                                 |  |
| 23C. PHYSICIAN'S NAME (Type) David S. Zee, M.D.                                                                                                                                                                                                                                                               |  |                                                                                                        |  | 23D. ADDRESS The Johns Hopkins Hospital                                                                                                                  |  |                                                                                 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL                                                                                                                                                                                                                                                               |  | 24B. DATE 15-Nov-71                                                                                    |  | 24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY                                                                                                     |  | 24D. LOCATION (City, town, or county) (State) BALTO CO., MD.                    |  |
| 25A. DATE REC'D BY HEALTH DEPT. NOV 15 1971                                                                                                                                                                                                                                                                   |  | 25B. NAME OF REGISTRAR Robert E. Sabin, R.D.                                                           |  | 25C. FUNERAL DIRECTOR                                                                                                                                    |  | ADDRESS 11111 FURNAL HOME, DUNDALK, MD.                                         |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                    |  |                                                                                                                        |  |                                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|
| B-260 71 10479                                                                                                                                                                                                                                                                                     |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                       |  | X REG. NO. 71 10479                                                                           |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                          |  | 1. NAME OF DECEASED<br>(Type or Print) JOHN R. BUCHER                                                                  |  | 2. DATE AND HOUR OF DEATH<br>11-9-71 18                                                       |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MD. B. COUNTY BALTO. |  | 5300                                                                                          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Church Home and Hospital<br>100 N Broadway St.<br>Baltimore MD 21231                                                                                                               |  | C. CITY OR TOWN<br>BALTIMORE                                                                                           |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| E. STREET AND NUMBER<br>1912 BARRY RD. 21224                                                                                                                                                                                                                                                       |  | 5. SEX<br>Male                                                                                                         |  | 6. RACE<br>White                                                                              |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                        |  | 8. DATE OF BIRTH<br>1-26-30                                                                                            |  | 9. AGE (In years last birthday) 41                                                            |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>JACK TRANSPORT DRIVER                                                                                                                                                                               |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>TRUCKING                                                                          |  | 11. BIRTHPLACE (State or foreign country)<br>MD.                                              |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                |  | 13. FATHER'S NAME<br>CLAUDE BUCHER                                                                                     |  | 14. MOTHER'S MAIDEN NAME<br>HAZEL SILVERWOOD                                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                           |  | 16. SOCIAL SECURITY NO.<br>2 1122-2194                                                                                 |  | 17. INFORMANT<br>A. Served none M.D.<br>Church Home Hosp. Baltimore                           |  |
| 18. 412.2 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>Chronic Renal Failure many years                                                   |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Nephrosclerosis                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>Arteriosclerotic Cardiovascular disease many years                                                                        |  | (C) DUE TO, OR AS A CONSEQUENCE OF:<br>Coronary artery disease, lower lobe pneumonia, Diabetes                         |  |                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                             |  |                                                                                                                        |  |                                                                                               |  |
| 19A. DATE OF OPERATION<br>NONE                                                                                                                                                                                                                                                                     |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>NONE                                                               |  | 20A. AUTOPSY? (Yes or No)<br>NONE                                                             |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                               |  |                                                                                                                        |  |                                                                                               |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br>NONE                                                                                                                                                                                                      |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>NONE                       |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>NONE              |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)<br>NONE                                                                                                                                                                                                                                  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>              |  | 21F. HOW DID INJURY OCCUR?<br>NONE                                                            |  |
| 22. I certify that (I) (this hospital) attended the deceased from 11-9-71 to 11-9-71 that (I) (we) last saw the deceased alive on 11-9-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                        |  |                                                                                               |  |
| 23A. SIGNATURE<br>CORAZON VERGARA M.D.                                                                                                                                                                                                                                                             |  |                                                                                                                        |  | 23B. DATE SIGNED<br>11-10-71                                                                  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>CORAZON Z. VERGARA, M.D.                                                                                                                                                                                                                                           |  |                                                                                                                        |  | 23D. ADDRESS<br>100 N. Broadway Balt. Md. 21231                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                 |  | 24B. DATE<br>NOV. 12, 1971                                                                                             |  | 24C. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN CEMETERY                                       |  |
| 24D. LOCATION<br>BALTIMORE CO., MD.                                                                                                                                                                                                                                                                |  | 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 15 1971                                                                         |  |                                                                                               |  |
| 25B. NAME OF REGISTRAR<br>Robert E. Fisher, M.D.                                                                                                                                                                                                                                                   |  | 25C. FUNERAL DIRECTOR<br>ULLRICH FUNERAL HOME 2112 DUNDALK AVE 21222                                                   |  |                                                                                               |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                             |                                                                                                                                  | 71 10480                                                                             |                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                             |                                                                                                                                  | REG. NO. 71 10480                                                                    |                                                                                                  |
| BIRTH NO. <u>H-300</u>                                                                                                                                                                                                                                                                                                                                 |                  | 71 10480                                                                                                                                                    |                                                                                                                                  |                                                                                      |                                                                                                  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>HOOD EMMA</u>                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><u>11.10.71</u> <u>13.10 p.m.</u>                                                                   |                                                                                      |                                                                                                  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <u>Md</u> B. COUNTY <u>2611</u> |                                                                                      |                                                                                                  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>48 Maryland General Hosp</u>                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                             | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |                                                                                      |                                                                                                  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                             | E. STREET AND NUMBER<br><u>3308 Hudson St.</u>                                                                                   |                                                                                      |                                                                                                  |
| 5. SEX <u>F</u>                                                                                                                                                                                                                                                                                                                                        | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9-2-13</u>                                                                                                | 9. AGE (In years last birthday)<br><u>58</u>                                         | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>unemployed</u>                                                                                                                                                                                                                                       |                  |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                |                                                                                      | 11. BIRTHPLACE (State or foreign country)<br><u>Md</u>                                           |
| 13. FATHER'S NAME<br><u>Harry</u>                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><u>Mamie Schaffer</u>                                                                                |                                                                                      |                                                                                                  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                  |                  |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><u>-</u>                                                                                              |                                                                                      | 17. INFORMANT<br><u>Mrs. Dorothy Balcher</u> ADDRESS<br><u>6506 No. Pt. Road</u><br><u>21219</u> |
| 18. <u>194X I</u> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                     |                                                                                      |                                                                                                  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><u>Ca of breast &amp; liver metastases</u>                                                                                                                                                                                                                                                           |                  |                                                                                                                                                             | <u>7 days</u>                                                                                                                    |                                                                                      |                                                                                                  |
| 1. This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.                                                                                                                                                                                                           |                  |                                                                                                                                                             | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                              |                                                                                      |                                                                                                  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                             | (B) <u>Hiatal hernia</u> DUE TO, OR AS A CONSEQUENCE OF:                                                                         |                                                                                      |                                                                                                  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                              |                  |                                                                                                                                                             | (C) _____                                                                                                                        |                                                                                      |                                                                                                  |
| II                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                             |                                                                                                                                  |                                                                                      |                                                                                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                       |                  |                                                                                                                                                             |                                                                                                                                  |                                                                                      |                                                                                                  |
| 19A. DATE OF OPERATION<br><u>None</u>                                                                                                                                                                                                                                                                                                                  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                  | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>                        |                                                                                                  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><u>No</u>                                                                                                                                                                                                                                                     |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)             |                                                                                                  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                              |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                  | 21F. HOW DID INJURY OCCUR?                                                           |                                                                                                  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11-4</u> 19 <u>71</u> to <u>11-10</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11-4</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |                                                                                                                                                             |                                                                                                                                  |                                                                                      |                                                                                                  |
| 23A. SIGNATURE<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                             |                                                                                                                                  | 23B. DATE SIGNED<br><u>11.10.71</u>                                                  |                                                                                                  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>C. GAKUBA</u>                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                             |                                                                                                                                  | 23D. ADDRESS<br><u>Maryland General</u>                                              |                                                                                                  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                              |                  | 24B. DATE<br><u>11-15-71</u>                                                                                                                                |                                                                                                                                  | 24C. NAME of CEMETERY or CREMATORY<br><u>Landon Pk.</u>                              |                                                                                                  |
| 24D. LOCATION<br><u>Balto</u>                                                                                                                                                                                                                                                                                                                          |                  | 24E. CITY, town, or county<br><u>Md.</u>                                                                                                                    |                                                                                                                                  | 24F. STATE<br><u>Md.</u>                                                             |                                                                                                  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 15 1971</u>                                                                                                                                                                                                                                                                                                  |                  | 25B. NAME OF REGISTRAR<br><u>Robert E. Fisher, M.D.</u>                                                                                                     |                                                                                                                                  | 25C. FUNERAL DIRECTOR<br><u>Thelma J. Hoffmann</u> ADDRESS<br><u>3218 Hudson St.</u> |                                                                                                  |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                          |  |                                                                                                                                                          |  |                                                                                                          |  |                                           |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|-------------------------------------------|--|
| S-553                                                                                                                                                                                                                                                                                                                                     |  | 71 10481                                                                                                                                 |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                         |  | CERTIFICATE OF DEATH                                                                                     |  | REG. NO. 71 10481                         |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                 |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Leta F. Simmonds</u>                                                                           |  |                                                                                                                                                          |  | 2. DATE AND HOUR OF DEATH<br><u>November 11, 1971</u>                                                    |  |                                           |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                    |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u> |  |                                                                                                                                                          |  | 5. CITY OR TOWN <u>BALTIMORE</u>                                                                         |  |                                           |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Anderson Nursing Home</u>                                                                                                                                                                                                                                                                      |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                     |  |                                                                                                                                                          |  | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  |                                           |  |
| 6. SEX <u>F</u>                                                                                                                                                                                                                                                                                                                           |  | 6. RACE <u>W</u>                                                                                                                         |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>4-29-1885</u>                                                                     |  | 9. AGE (In years last birthday) <u>86</u> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>At Home</u>                                                                                                                                                                                                                             |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                        |  | 11. BIRTHPLACE (State or foreign country)<br><u>N.Y.</u>                                                                                                 |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                            |  |                                           |  |
| 13. FATHER'S NAME<br><u>Hezekiah FANNING</u>                                                                                                                                                                                                                                                                                              |  | 14. MOTHER'S MAIDEN NAME<br><u>McConnell</u>                                                                                             |  |                                                                                                                                                          |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |  |                                           |  |
| 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                   |  | 17. INFORMANT<br><u>Virgil Simmonds - 3742 Sylvan Dr #7</u>                                                                              |  |                                                                                                                                                          |  | ADDRESS                                                                                                  |  |                                           |  |
| 18. <u>485X1</u>                                                                                                                                                                                                                                                                                                                          |  | CAUSE OF DEATH<br><u>BRONCHOPNEUMONIA</u>                                                                                                |  |                                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>4 DAYS</u>                                            |  |                                           |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.)                                                                                                                                             |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                   |  |                                                                                                                                                          |  |                                                                                                          |  |                                           |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                            |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                      |  |                                                                                                                                                          |  |                                                                                                          |  |                                           |  |
| (C)                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          |  |                                                                                                                                                          |  |                                                                                                          |  |                                           |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                    |  | <u>CEREBRAL ARTERIOSCLEROSIS</u>                                                                                                         |  |                                                                                                                                                          |  | <u>10 YRS.</u>                                                                                           |  |                                           |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                    |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                     |  |                                           |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                     |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                 |  |                                                                                                          |  |                                           |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                 |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                   |  | 21F. HOW DID INJURY OCCUR?                                                                                                                               |  |                                                                                                          |  |                                           |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>JULY 24, 1970</u> to <u>NOV. 11, 1971</u> that (I) (we) last saw the deceased alive on <u>NOV. 11, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                          |  |                                                                                                                                                          |  |                                                                                                          |  |                                           |  |
| 23A. SIGNATURE<br><u>Marvin Goldstein, M.D.</u>                                                                                                                                                                                                                                                                                           |  | DEGREE                                                                                                                                   |  | Attending <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>                                |  | 23B. DATE SIGNED<br><u>Nov. 12, 1971</u>                                                                 |  |                                           |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>MARVIN GOLDSTEIN, M.D.</u>                                                                                                                                                                                                                                                                             |  | DEGREE                                                                                                                                   |  | 23D. ADDRESS<br><u>6001 PARK HEIGHTS AVE. BALTIMORE, MD.</u>                                                                                             |  |                                                                                                          |  |                                           |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                 |  | 24B. DATE<br><u>11-15-71</u>                                                                                                             |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Oswegatchie Cemetery - Oswegatchie, New York</u>                                                                |  | 24D. LOCATION (City, town, or county) (State)                                                            |  |                                           |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 15 1971</u>                                                                                                                                                                                                                                                                                     |  | 25B. NAME OF REGISTRAR<br><u>E. Taylor, R.D.</u>                                                                                         |  | 25C. FUNERAL DIRECTOR<br><u>Armanist Funeral Chapel - 4604 Liberty Hts</u>                                                                               |  | ADDRESS                                                                                                  |  |                                           |  |

Anderson, William H.

F U

At Home

Herrick, Fanning

4-22-1882 24  
3440 Sylvan St.  
N.Y.

McConnell

1001 2nd Ave - 2nd Floor

Nov 11-12-71 Concrete Cemetery - Concrete, New York

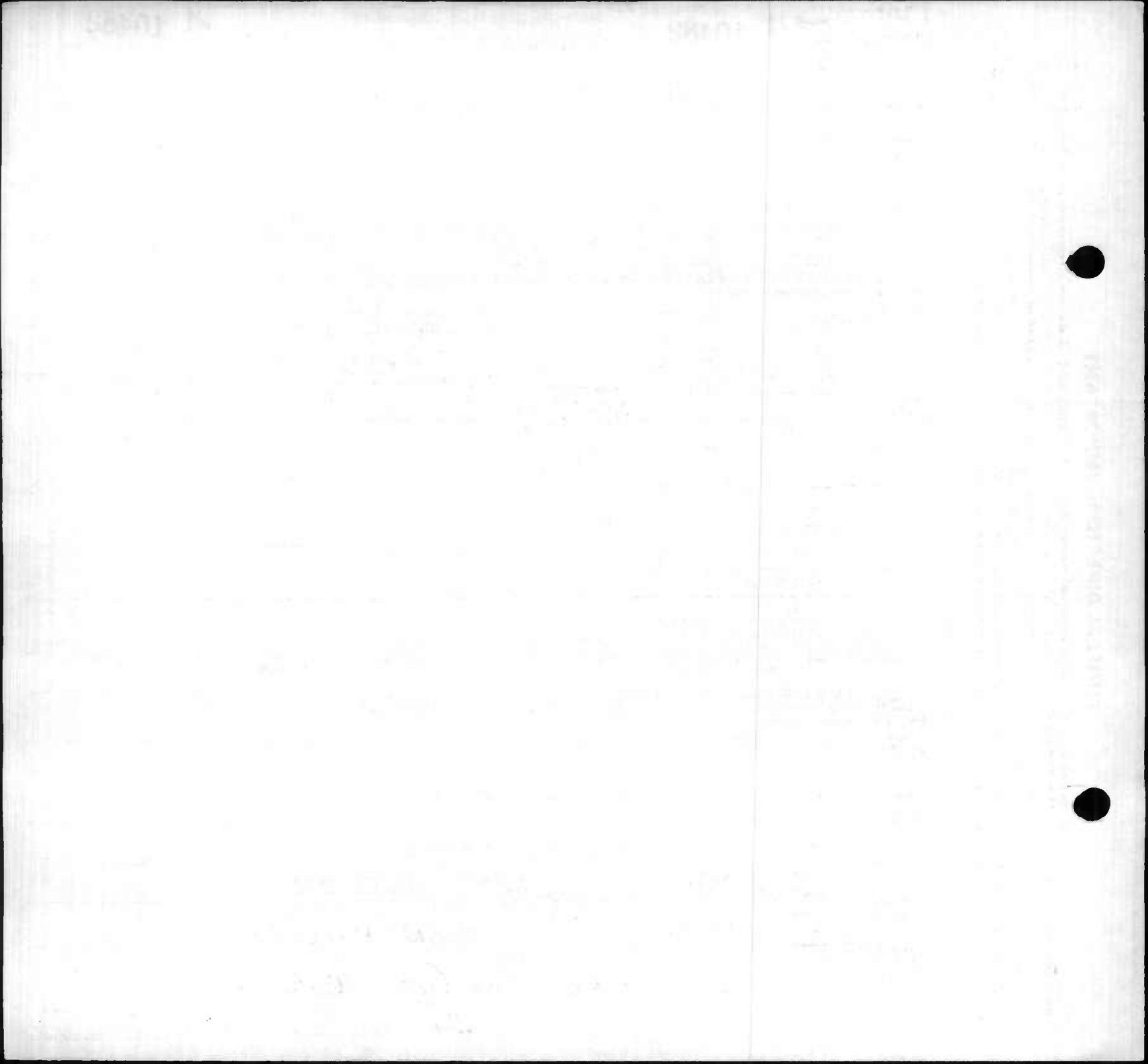
Amherst, New York



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                           |                                              |                                                              |  |
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| B-626                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     | 71 10482                                                                                                                                                    |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                          |                                              | REG. NO. 71 10482                                            |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                             |  | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                      |                                              |                                                              |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>BURGGRAF JANE E.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br><b>NOV. 11 1971 7:50 P.M.</b>                                                                                                                                                                                                                                                                                |                                              |                                                              |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION <b>4.4 UNION MEMORIAL HOSPITAL</b><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                        |                     |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>CITY OF BALTIMORE</b><br>B. COUNTY <b>5300</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>6601 ENGLISH OAK RD.</b> |                                              |                                                              |  |
| 5. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>07-06-20</b>                                                                                                                                                                                                                                                                                                       | 9. AGE (In years last birthday)<br><b>51</b> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                             |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>                                                                                                                                                                                                                                                                                             |                                              | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     |                                                                                                                                                             |  | 13. FATHER'S NAME<br><b>HARVEY E. ROZAK</b>                                                                                                                                                                                                                                                                                               |                                              |                                                              |  |
| 14. MOTHER'S MAIDEN NAME<br><b>STRAIN, ANNA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                             |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service<br><b>No</b>                                                                                                                                                                                                                       |                                              |                                                              |  |
| 16. SOCIAL SECURITY NO.<br><b>219-07-1855</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     |                                                                                                                                                             |  | 17. INFORMANT<br><b>WILLIAM H. BURGERME</b>                                                                                                                                                                                                                                                                                               |                                              |                                                              |  |
| 18. <b>571.0 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br><b>Lenned's cirrhosis</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     |                                                                                                                                                             |  | ADDRESS<br><b>228 LINDEN AVE. Towson, Md.</b>                                                                                                                                                                                                                                                                                             |                                              |                                                              |  |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                           |                                              |                                                              |  |
| 19. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                           |                                              |                                                              |  |
| 20A. AUTOPSY (Yes or No)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                        |  |                                                                                                                                                                                                                                                                                                                                           |                                              |                                                              |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                  |                                              |                                                              |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     | 21E. INJURY OCCURRED                                                                                                                                        |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                |                                              |                                                              |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     | 21E. INJURY OCCURRED                                                                                                                                        |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                |                                              |                                                              |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     | 21E. INJURY OCCURRED                                                                                                                                        |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                |                                              |                                                              |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11-05-71</b> 19 to <b>11-11-71</b> 19<br>that (I) (we) lost saw the deceased alive on <b>11-11-71</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                               |                     |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                           |                                              |                                                              |  |
| 23A. SIGNATURE<br><b>Jairo Ramirez MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                             |  | 23B. DATE SIGNED<br><b>11-11-71</b>                                                                                                                                                                                                                                                                                                       |                                              | 23C. PHYSICIAN'S NAME (Type)<br><b>JAIRO RAMIREZ MD</b>      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     | 24B. DATE                                                                                                                                                   |  | 24C. NAME OF CEMETERY or CREMATORY                                                                                                                                                                                                                                                                                                        |                                              | 24D. LOCATION (City, town, or county) (State)                |  |
| <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     | <b>11-15-71</b>                                                                                                                                             |  | <b>LOBBINE PARK Cem.</b>                                                                                                                                                                                                                                                                                                                  |                                              | <b>Woodman, BALTO. MD.</b>                                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 15 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, Md.</b>                                                                                                                                                                                                                                                                                    |                                              | 25C. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, Md.</b>  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                             |                                                                                                                                                             |                                                                                                                                                                                                     | REG. NO. <u>71 10483</u>                                                                                        |                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| S-512 71 10483                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                             | BIRTH NO.                                                                                                                                                   |                                                                                                                                                                                                     |                                                                                                                 |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <b>SIMPSON, CHARLES WYCKLIFF</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                             |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>NOVEMBER 10, 1971 3:25A.M.</b>                                                                                                                                      |                                                                                                                 |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>                                                         |                                                                                                                 |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>40 ST. AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                             |                                                                                                                                                             | C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                         |                                                                                                                 |                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                             |                                                                                                                                                             | E. STREET AND NUMBER<br><b>4005 Maryland Place</b>                                                                                                                                                  |                                                                                                                 |                                                           |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6. RACE<br><b>CAUCASIAN</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>09 30 86</b>                                                                                                                                                                 | 9. AGE (In years last birthday)<br><b>85</b>                                                                    | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SALESMAN</b>                                                                                                                                                                                                                                                                                                                                                                        |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>ELECTROLUX</b>                                                                                                      |                                                                                                                                                                                                     | 11. BIRTHPLACE (State or foreign country)<br><b>PENNSYLVANIA</b>                                                |                                                           |
| 13. FATHER'S NAME<br><b>JOHN SIMPSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>ALICE CARY</b>                                                                                                                                                       |                                                                                                                 |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                   |                             | 16. SOCIAL SECURITY NO.<br><b>159149667</b>                                                                                                                 |                                                                                                                                                                                                     | 17. INFORMANT ADDRESS<br><b>WILKENS AVES. BALTO. MD. 21229</b><br><b>ST. AGNES HOSPITAL RECORDS-CATON &amp;</b> |                                                           |
| 18. <b>410.7 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                         |                             |                                                                                                                                                             | (A) IMMEDIATE CAUSE <b>Acute Myocardial Infarction 9 hours</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>ASCVD and occlusion coronary artery</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                                                                                                                 |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                |                             |                                                                                                                                                             |                                                                                                                                                                                                     |                                                                                                                 |                                                           |
| 19A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                     | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>                                                                         |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                 |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                        |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                             |                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                                     | 21F. HOW DID INJURY OCCUR?                                                                                      |                                                           |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>NOVEMBER 09 19 71</b> to <b>NOVEMBER 10 19 71</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>NOVEMBER 10 19 71</b> and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (didn't) view the body after death. |                             |                                                                                                                                                             |                                                                                                                                                                                                     |                                                                                                                 |                                                           |
| 23A. SIGNATURE<br><b>Rahman Karim M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |                             |                                                                                                                                                             |                                                                                                                                                                                                     | 23B. DATE SIGNED<br><b>11/10/71</b>                                                                             |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>RAHMAN KARIAM M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |                             |                                                                                                                                                             |                                                                                                                                                                                                     | 23D. ADDRESS<br><b>CATON &amp; WILKENS AVES. BALTO., MD. 21229</b>                                              |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |                             | 24B. DATE<br><b>11-13-71</b>                                                                                                                                |                                                                                                                                                                                                     | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Washington Cemetery</b>                                                |                                                           |
| 24D. LOCATION (City, town, or county) (State)<br><b>Washington, Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                             | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 15 1971</b>                                                                                                       |                                                                                                                                                                                                     |                                                                                                                 |                                                           |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Farber, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |                             | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>                                                                          |                                                                                                                                                                                                     |                                                                                                                 |                                                           |

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ALLAN YOUNG

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ALICE (BERRY)

1. *Chlorophyll a* (Chl *a*)

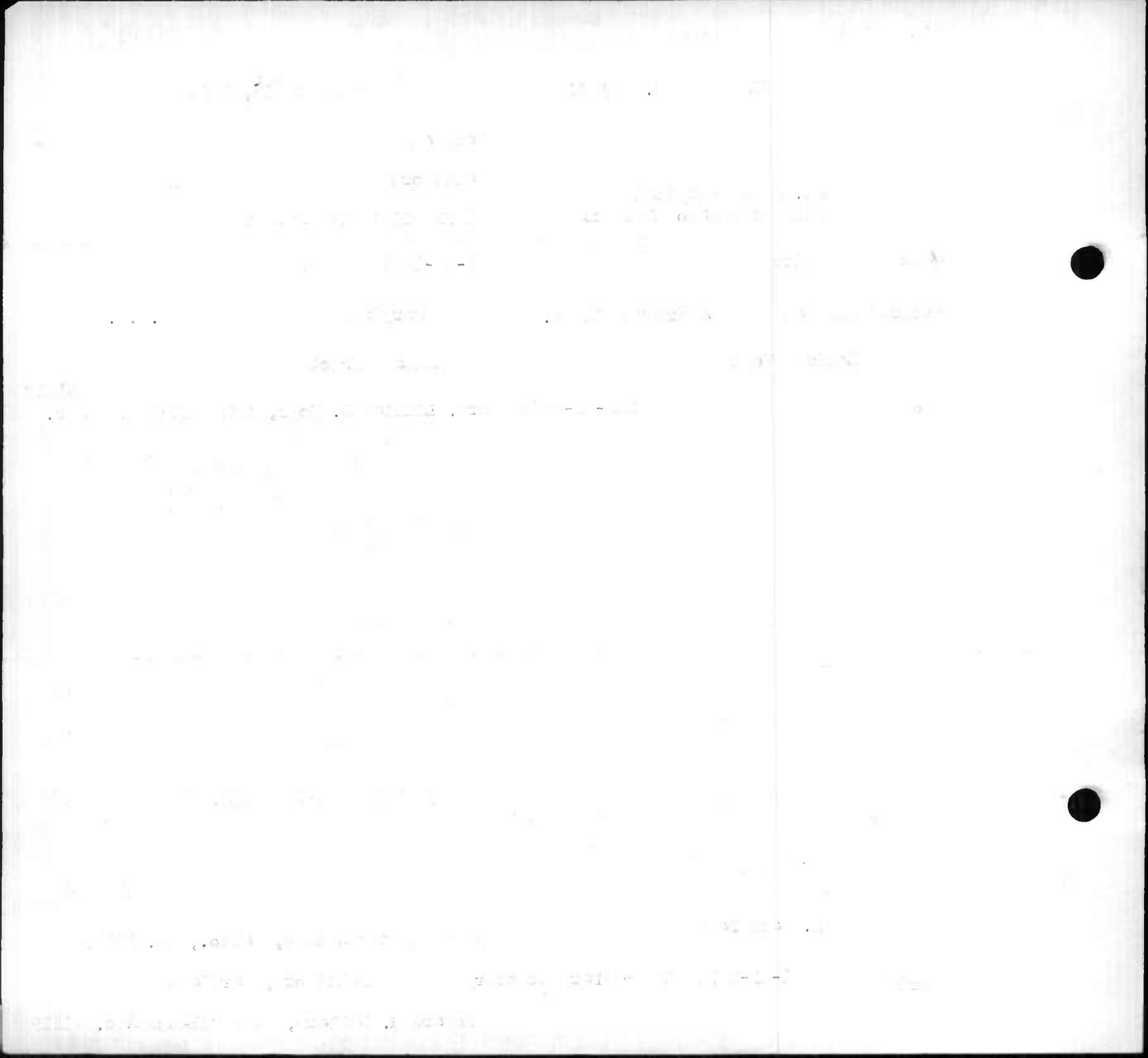
DATE: 2011-03-15

15

# FUNERAL DIRECTOR: IMPORTANT

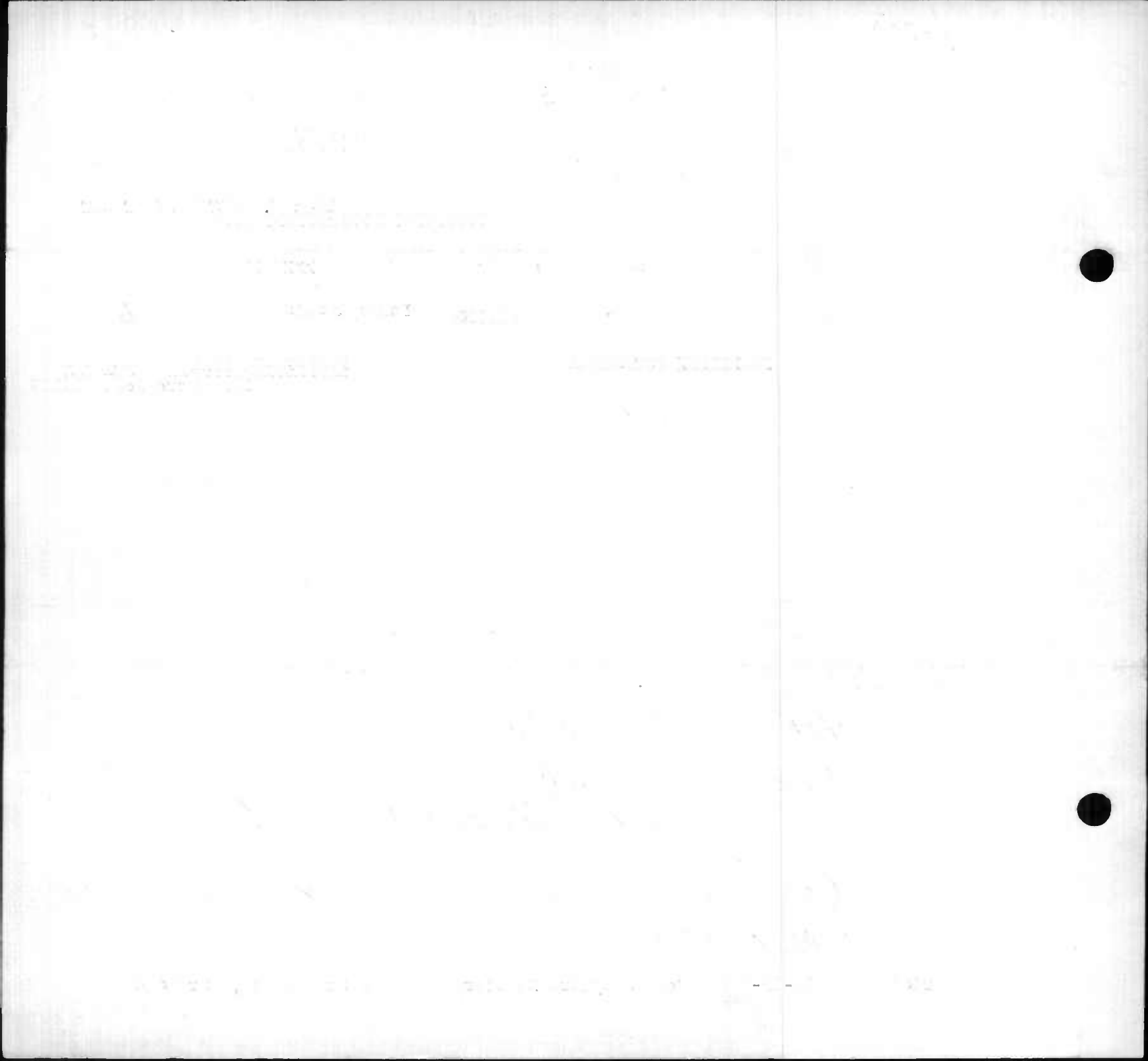
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                                             |                                                                                                                                                                       |                                                                      |                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| V-230 71 10484                                                                                                                                                                                                                                                                                                  |                  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                    |                                                                                                                                                                       | 71 10484                                                             |                                                                                               |
| BIRTH NO.                                                                                                                                                                                                                                                                                                       |                  | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                      |                                                                                                                                                                       | 2. DATE AND HOUR OF DEATH                                            |                                                                                               |
|                                                                                                                                                                                                                                                                                                                 |                  | SAMUEL C. VOGT                                                                                                                                              |                                                                                                                                                                       | November 10, 1971                                                    |                                                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                          |                  |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                                 |                                                                      |                                                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)                                                                                                                                                                                                    |                  |                                                                                                                                                             | A. STATE<br>B. COUNTY                                                                                                                                                 |                                                                      |                                                                                               |
| 40 St. Agnes Hospital<br>Wilkins & Caton Avenues                                                                                                                                                                                                                                                                |                  |                                                                                                                                                             | Maryland                                                                                                                                                              |                                                                      |                                                                                               |
|                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                                             | C. CITY OR TOWN<br>Baltimore                                                                                                                                          |                                                                      | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                                             | E. STREET AND NUMBER<br>1073 Wilmington Avenue                                                                                                                        |                                                                      |                                                                                               |
| 5. SEX<br>Male                                                                                                                                                                                                                                                                                                  | 6. RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                                       | 8. DATE OF BIRTH<br>7-30-1902                                        | 9. AGE (In years last birthday)<br>69                                                         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired Dockman                                                                                                                                                                                                  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>American Oil Co.                                                                                                       |                                                                                                                                                                       | 11. BIRTHPLACE (State or foreign country)<br>Maryland                |                                                                                               |
| 13. FATHER'S NAME<br>Louis Vogt                                                                                                                                                                                                                                                                                 |                  | 14. MOTHER'S MAIDEN NAME<br>Anna Nagel                                                                                                                      |                                                                                                                                                                       | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                               |                                                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                  |                  | 16. SOCIAL SECURITY NO.<br>215-03-5060                                                                                                                      |                                                                                                                                                                       | 17. INFORMANT<br>Mrs. Lillian C. Vogt, 1073 Wilmington Ave.          |                                                                                               |
|                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                                             |                                                                                                                                                                       | ADDRESS<br>21223                                                     |                                                                                               |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |                                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Acute Myocardial Infarction<br>ASCVD.<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                                                                      |                                                                                               |
| 19. DATE OF OPERATION                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                             | 19A. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                      |                                                                      |                                                                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                           |                  |                                                                                                                                                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                              |                                                                      |                                                                                               |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                             |                                                                      |                                                                                               |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                        |                  |                                                                                                                                                             | 21F. HOW DID INJURY OCCUR?                                                                                                                                            |                                                                      |                                                                                               |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 13 1969 to 11/10 1971 that (I) (we) lost saw the deceased alive on Feb 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.       |                  |                                                                                                                                                             |                                                                                                                                                                       |                                                                      |                                                                                               |
| 23A. SIGNATURE<br>Earl Pass                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                             | 23B. DATE SIGNED<br>11/10/71                                                                                                                                          |                                                                      |                                                                                               |
| 23C. PHYSICIAN'S NAME (Type)<br>I. Earl Pass                                                                                                                                                                                                                                                                    |                  |                                                                                                                                                             | 23D. ADDRESS<br>4001 Wilkins Avenue, Balto., Md. 21229                                                                                                                |                                                                      |                                                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                              |                  | 24B. DATE<br>11-13-1971                                                                                                                                     |                                                                                                                                                                       | 24C. NAME of CEMETERY or CREMATORY<br>Loudon Park Cemetery           |                                                                                               |
|                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                                             |                                                                                                                                                                       | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland |                                                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 15 1971                                                                                                                                                                                                                                                                  |                  |                                                                                                                                                             | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, R.D.                                                                                                                      |                                                                      |                                                                                               |
|                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                                             | 25C. FUNERAL DIRECTOR<br>Howard H. Hubbard, 4107 Wilkins Ave. 21229                                                                                                   |                                                                      |                                                                                               |
|                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                                             | ADDRESS                                                                                                                                                               |                                                                      |                                                                                               |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                         |  |          |  |                                                                                                                      |  |          |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------|--|----------------------------------------------------------------------------------------------------------------------|--|----------|--|
| Y-320                                                                                                                                                                                                                                                                                                                                   |  | 71 10485 |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                     |  | 71 10485 |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                               |  |          |  | CERTIFICATE OF DEATH                                                                                                 |  |          |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ELIZABETH GATES</b>                                                                                                                                                                                                                                                                           |  |          |  | 2. DATE AND HOUR OF DEATH<br><b>11-10-71 9:50 AM</b>                                                                 |  |          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                  |  |          |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                |  |          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Bon. Secours Hospital</b>                                                                                                                                                                                                                                                                    |  |          |  | A. STATE & COUNTY<br><b>MD XXXXXXXX 1802</b>                                                                         |  |          |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                    |  |          |  | C. CITY OR TOWN<br><b>BALTO</b>                                                                                      |  |          |  |
| 34                                                                                                                                                                                                                                                                                                                                      |  |          |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |  |          |  |
| 5. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                      |  |          |  | 6. RACE<br><b>W</b>                                                                                                  |  |          |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                             |  |          |  | 8. DATE OF BIRTH<br><b>2-6-1899</b>                                                                                  |  |          |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NONE</b>                                                                                                                                                                                                                              |  |          |  | 9. AGE (in years lost birthday)<br><b>72</b>                                                                         |  |          |  |
| 10B. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                                                                                                                                                                                                                                                                                           |  |          |  | 11. BIRTHPLACE (State or foreign country)<br><b>PA Pennsylvania</b>                                                  |  |          |  |
| 13. FATHER'S NAME<br><b>George XXXXXXXX OSTRANDER</b>                                                                                                                                                                                                                                                                                   |  |          |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                           |  |          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>-</b>                                                                                                                                                                                                                    |  |          |  | 14. MOTHER'S MAIDEN NAME<br><b>may XXXXXXXX STANLEY</b>                                                              |  |          |  |
| 16. SOCIAL SECURITY NO.<br><b>212-30-1895</b>                                                                                                                                                                                                                                                                                           |  |          |  | 17. INFORMANT<br><b>Rachel Whitcomb</b>                                                                              |  |          |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)<br><b>197.8 I</b>                                                                                                                    |  |          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                         |  |          |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                          |  |          |  | (A) IMMEDIATE CAUSE <b>congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF:                               |  |          |  |
|                                                                                                                                                                                                                                                                                                                                         |  |          |  | (B) <b>Ca of liver &amp; metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                           |  |          |  |
|                                                                                                                                                                                                                                                                                                                                         |  |          |  | (C) <b>pleural effusion</b>                                                                                          |  |          |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                  |  |          |  |                                                                                                                      |  |          |  |
| 19A. DATE OF OPERATION<br><b>NONE</b>                                                                                                                                                                                                                                                                                                   |  |          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>                                                         |  |          |  |
| 20A. AUTOPSY? (Yes or No)<br><b>-</b>                                                                                                                                                                                                                                                                                                   |  |          |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                 |  |          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)<br><b>N/A</b>                                                                                                                                                                                                                                     |  |          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>N/A</b>               |  |          |  |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                                                                                                                                                                                             |  |          |  |                                                                                                                      |  |          |  |
| 21D. TIME OF INJURY (Approx.)<br><b>N/A</b>                                                                                                                                                                                                                                                                                             |  |          |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> While Not At Work <input checked="" type="checkbox"/> |  |          |  |
| 21F. HOW DID INJURY OCCUR?<br><b>N/A</b>                                                                                                                                                                                                                                                                                                |  |          |  |                                                                                                                      |  |          |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11-3-71</b> to <b>11-10-71</b> and that (I) (we) last saw the deceased alive on <b>11-10-71 (9:50 AM)</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |          |  |                                                                                                                      |  |          |  |
| 23A. SIGNATURE<br><b>Antony</b>                                                                                                                                                                                                                                                                                                         |  |          |  | 23B. DATE SIGNED<br><b>11-10-71</b>                                                                                  |  |          |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>GERARDO M LOPEZ</b>                                                                                                                                                                                                                                                                                  |  |          |  | 23D. ADDRESS<br><b>Bon Secours Hospital</b>                                                                          |  |          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                               |  |          |  | 24B. DATE<br><b>11-13-1971</b>                                                                                       |  |          |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Good Shepherd Cemetery</b>                                                                                                                                                                                                                                                                     |  |          |  | 24D. LOCATION (City, town, or county) (State)<br><b>Howard County, Maryland</b>                                      |  |          |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 15 1971</b>                                                                                                                                                                                                                                                                                   |  |          |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Farley, M.D.</b>                                                              |  |          |  |
| 25C. FUNERAL DIRECTOR<br><b>Hubert J. Lumbard</b>                                                                                                                                                                                                                                                                                       |  |          |  | ADDRESS<br><b>Hubert J. Lumbard</b>                                                                                  |  |          |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                |                          |                                                                                                                                                                           |                                                                     | X                                                                                                                                                                                                                                                                                                                                                  |                                                                      | REG. NO. 71 10486                                                                                                      |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|--|
| <b>L-250</b> 71 10486<br><b>BIRTH NO.</b>                                                                                                                                                                                                                                                                       |                          | <b>CERTIFICATE OF DEATH</b>                                                                                                                                               |                                                                     |                                                                                                                                                                                                                                                                                                                                                    |                                                                      |                                                                                                                        |  |
| <b>1. NAME OF DECEASED</b><br>(Type or Print) <b>LAWSON, EULA GREY</b>                                                                                                                                                                                                                                          |                          |                                                                                                                                                                           |                                                                     | <b>2. DATE AND HOUR OF DEATH</b><br><b>11 04 71</b> <b>8:40 A.M.</b>                                                                                                                                                                                                                                                                               |                                                                      |                                                                                                                        |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location)<br><b>40 ST. AGNES HOSPITAL WILKENS &amp; CATON AVE BALTIMORE, MARYLAND 21229</b>                                             |                          |                                                                                                                                                                           |                                                                     | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br><b>A. STATE MARYLAND B. COUNTY PRINCE GEORGE'S CO 6600</b><br><b>C. CITY OR TOWN LAUREL D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b><br><b>E. STREET AND NUMBER 1010 7TH ST. LAUREL MD 20810</b> |                                                                      |                                                                                                                        |  |
| <b>5. SEX FEMALE</b>                                                                                                                                                                                                                                                                                            | <b>6. RACE CAUCASIAN</b> | <b>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></b><br><b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b> | <b>8. DATE OF BIRTH 06/14/24</b>                                    | <b>9. AGE (In years lost birthday) 47</b>                                                                                                                                                                                                                                                                                                          | <b>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</b>     | <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b> |  |
| <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><i>Home</i>                                                                                                                                                                                                                                                         |                          |                                                                                                                                                                           | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>VIRGINIA</b> |                                                                                                                                                                                                                                                                                                                                                    | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>                 |                                                                                                                        |  |
| <b>13. FATHER'S NAME</b><br><b>CHARLIE GOINS</b>                                                                                                                                                                                                                                                                |                          |                                                                                                                                                                           |                                                                     | <b>14. MOTHER'S MAIDEN NAME</b><br><b>FRONA SHOUSES</b>                                                                                                                                                                                                                                                                                            |                                                                      |                                                                                                                        |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                    |                          | <b>16. SOCIAL SECURITY NO.</b><br><b>214201058</b>                                                                                                                        |                                                                     | <b>17. INFORMANT</b><br><b>ST. AGNES HOSPITAL - WILKENS &amp; CATON RECORDS</b>                                                                                                                                                                                                                                                                    |                                                                      |                                                                                                                        |  |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>211.9 I</b><br><b>Overwhelming Infection &amp; Severe Acidosis</b>                                |                          | <b>CAUSE OF DEATH</b><br><b>(A) IMMEDIATE CAUSE</b><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>Small bowel fistula</b>                                               |                                                                     |                                                                                                                                                                                                                                                                                                                                                    | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><b>4 days</b> |                                                                                                                        |  |
| <b>ANTECEDENT CAUSES</b><br><b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b>                                                                                                                                                                    |                          | <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>Post: Resection of small bowel</b>                                                                                       |                                                                     |                                                                                                                                                                                                                                                                                                                                                    | <b>30 days</b>                                                       |                                                                                                                        |  |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>                                                                                                                                                            |                          | <b>Familial Colonic Polyposis</b>                                                                                                                                         |                                                                     |                                                                                                                                                                                                                                                                                                                                                    | <b>20 yrs.</b>                                                       |                                                                                                                        |  |
| <b>19A. DATE OF OPERATION</b><br><b>9/13/71 &amp; 9/30/71</b>                                                                                                                                                                                                                                                   |                          | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br><b>Familial Colonic Polyposis - malignant</b>                                                                  |                                                                     | <b>20A. AUTOPSY? (Yes or No)</b><br><b>No</b>                                                                                                                                                                                                                                                                                                      |                                                                      | <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>                                            |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)                                                                                                                                                                                                                    |                          | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                           |                                                                     | <b>21C. WHERE DID INJURY OCCUR?</b>                                                                                                                                                                                                                                                                                                                |                                                                      | (If in Baltimore City, give exact location)                                                                            |  |
| <b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                |                          | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                          |                                                                     | <b>21F. HOW DID INJURY OCCUR?</b>                                                                                                                                                                                                                                                                                                                  |                                                                      |                                                                                                                        |  |
| <b>22. I certify that (X) (this hospital) attended the deceased from 09/04 1971 to 11/04 1971 that (X) (we) last saw the deceased alive on 11/04 1971 and that (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.</b> |                          |                                                                                                                                                                           |                                                                     |                                                                                                                                                                                                                                                                                                                                                    |                                                                      |                                                                                                                        |  |
| <b>23A. SIGNATURE</b><br><i>Sunthorn Malaisrie</i>                                                                                                                                                                                                                                                              |                          |                                                                                                                                                                           |                                                                     | <b>23B. DATE SIGNED</b><br><b>11/4/71</b>                                                                                                                                                                                                                                                                                                          |                                                                      | <b>23C. PHYSICIAN'S NAME (Type)</b><br><b>SUNTHORN MALAISRIE</b>                                                       |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>                                                                                                                                                                                                                                                |                          | <b>24B. DATE</b><br><b>11-7-71</b>                                                                                                                                        |                                                                     | <b>24C. NAME OF CEMETERY OR CREMATORY</b><br><b>Mountain View</b>                                                                                                                                                                                                                                                                                  |                                                                      | <b>24D. LOCATION</b> (City, town, or county) (State)<br><b>Seabrook Md.</b>                                            |  |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><b>NOV 15 1971</b>                                                                                                                                                                                                                                                    |                          | <b>25B. NAME OF REGISTRAR</b><br><b>Robert E. Fisher, M.D.</b>                                                                                                            |                                                                     | <b>25C. FUNERAL DIRECTOR</b><br><b>Donald J. H. Daniel, M.D.</b>                                                                                                                                                                                                                                                                                   |                                                                      | <b>ADDRESS</b>                                                                                                         |  |

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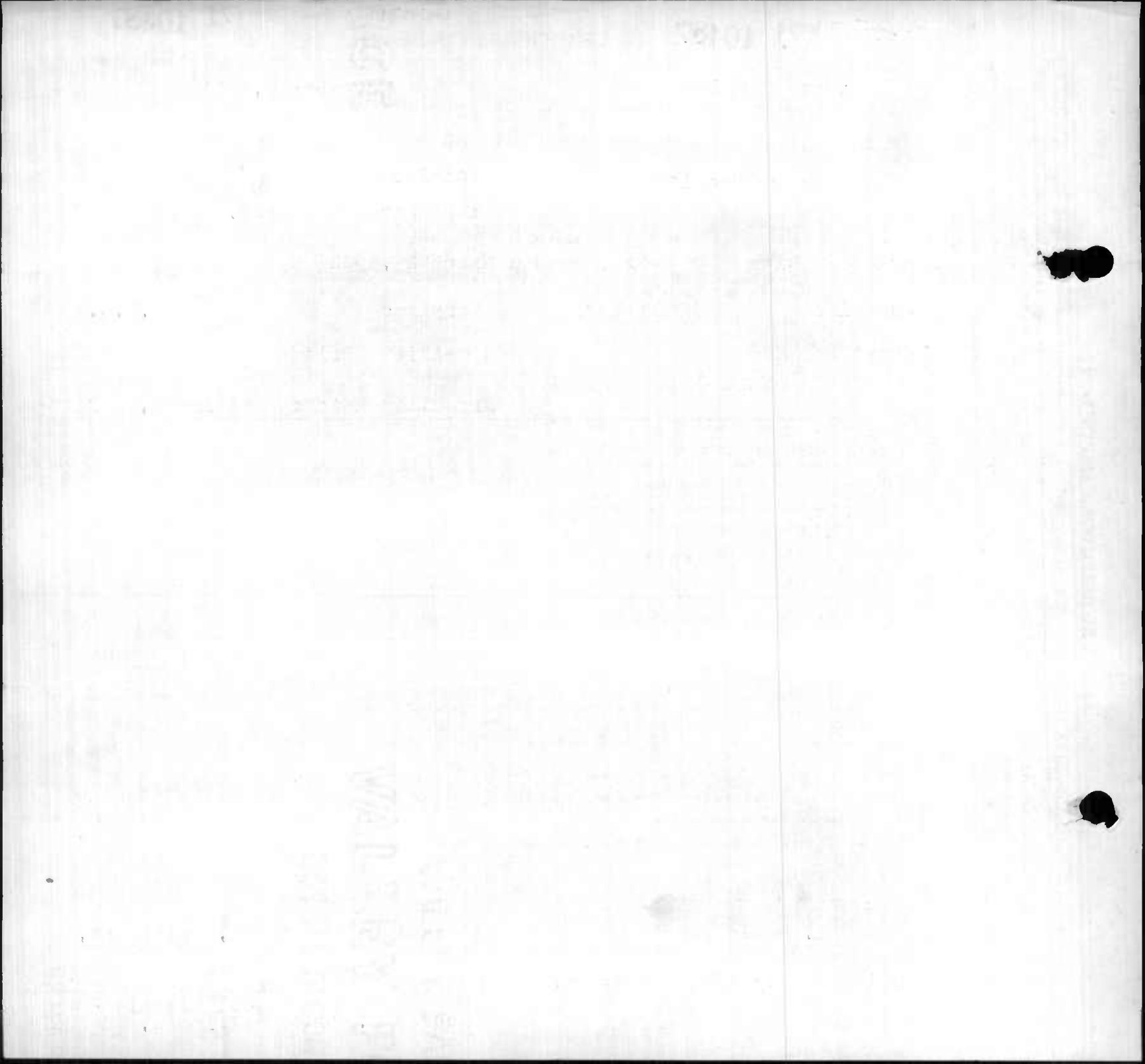
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

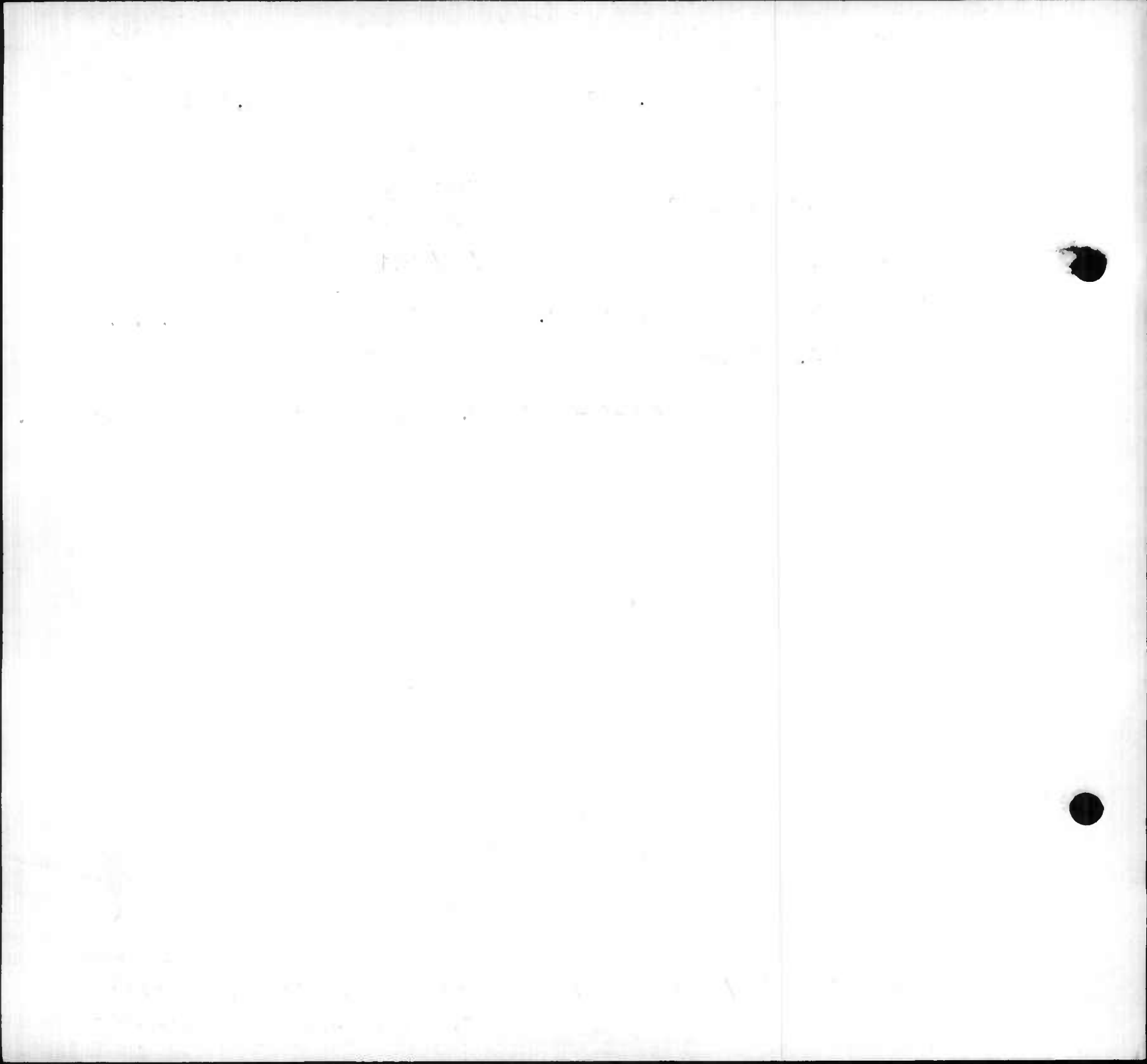
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                           |                              |                                                                                                                                                                                                        |                                           | REG. NO. <b>71 10487</b>                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------|
| H-655 71 10487                                                                                                                                                                                                                                                                                                                                             |                              |                                                                                                                                                                                                        |                                           | CERTIFICATE OF DEATH                                                                           |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                  |                              | 1. NAME OF DECEASED<br>(Type or Print) <b>Nora Harriman</b>                                                                                                                                            |                                           |                                                                                                |
| 2. DATE AND HOUR OF DEATH<br><b>November 7, 1971</b>                                                                                                                                                                                                                                                                                                       |                              | P. M.                                                                                                                                                                                                  |                                           |                                                                                                |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                     |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md</b> B. COUNTY <b>2404</b>                                                                      |                                           |                                                                                                |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>37 Mercy Hospital</b>                                                                                                                                                                                                                                                                                           |                              | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                            |                                           |                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                            |                              | E. STREET AND NUMBER<br><b>1600 Jackson Street.</b>                                                                                                                                                    |                                           |                                                                                                |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                    | 6. RACE<br><b>White</b>      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                            | 8. DATE OF BIRTH<br><b>March 28, 1902</b> | 9. AGE (In years last birthday) <b>69</b>                                                      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                            |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaker</b>                                                                                                                                                  |                                           | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                              |                              |                                                                                                                                                                                                        |                                           |                                                                                                |
| 13. FATHER'S NAME<br><b>Robert Bergman</b>                                                                                                                                                                                                                                                                                                                 |                              | 14. MOTHER'S MAIDEN NAME<br><b>Nellie OBrien</b>                                                                                                                                                       |                                           |                                                                                                |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                      |                              | 16. SOCIAL SECURITY NO.                                                                                                                                                                                |                                           | 17. INFORMANT<br><b>4000 5th Street</b><br><b>Mrs Ellen Kutchev Baltimore, Md 21225</b>        |
| 18. <b>398X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                              | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia H. D.</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>50 yrs.</b> |                                           |                                                                                                |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                           |                              |                                                                                                                                                                                                        |                                           |                                                                                                |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                     |                              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                       |                                           | 20A. AUTOPSY? (Yes or No)                                                                      |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                      |                              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                               |                                           | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                       |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                  |                              | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>                                                                                                 |                                           | 21F. HOW DID INJURY OCCUR?                                                                     |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10/6</b> 19 <b>49</b> to <b>11/7</b> 19 <b>71</b> , that (I) (we) last saw the deceased alive on <b>10/18</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                              |                                                                                                                                                                                                        |                                           |                                                                                                |
| 23A. SIGNATURE<br><b>C. Edward Leach</b>                                                                                                                                                                                                                                                                                                                   |                              | 23B. DATE SIGNED<br><b>11/9/71</b>                                                                                                                                                                     |                                           |                                                                                                |
| 23C. PHYSICIAN'S NAME (Type)<br><b>C. Edward Leach</b>                                                                                                                                                                                                                                                                                                     |                              | 23D. ADDRESS<br><b>#14 East Eager Street, Baltimore, Md</b>                                                                                                                                            |                                           |                                                                                                |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                  | 24B. DATE<br><b>11/11/71</b> | 24C. NAME OF CEMETERY or CREMATORY<br><b>Holy Cross Cemetery</b>                                                                                                                                       |                                           | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore 21225 Maryland</b>               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 15 1971</b>                                                                                                                                                                                                                                                                                                      |                              | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>                                                                                                                                                |                                           | 25C. FUNERAL DIRECTOR<br><b>George J. Gonce</b><br><b>4001 Ritchie Hwy Baltimore, Md 21225</b> |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

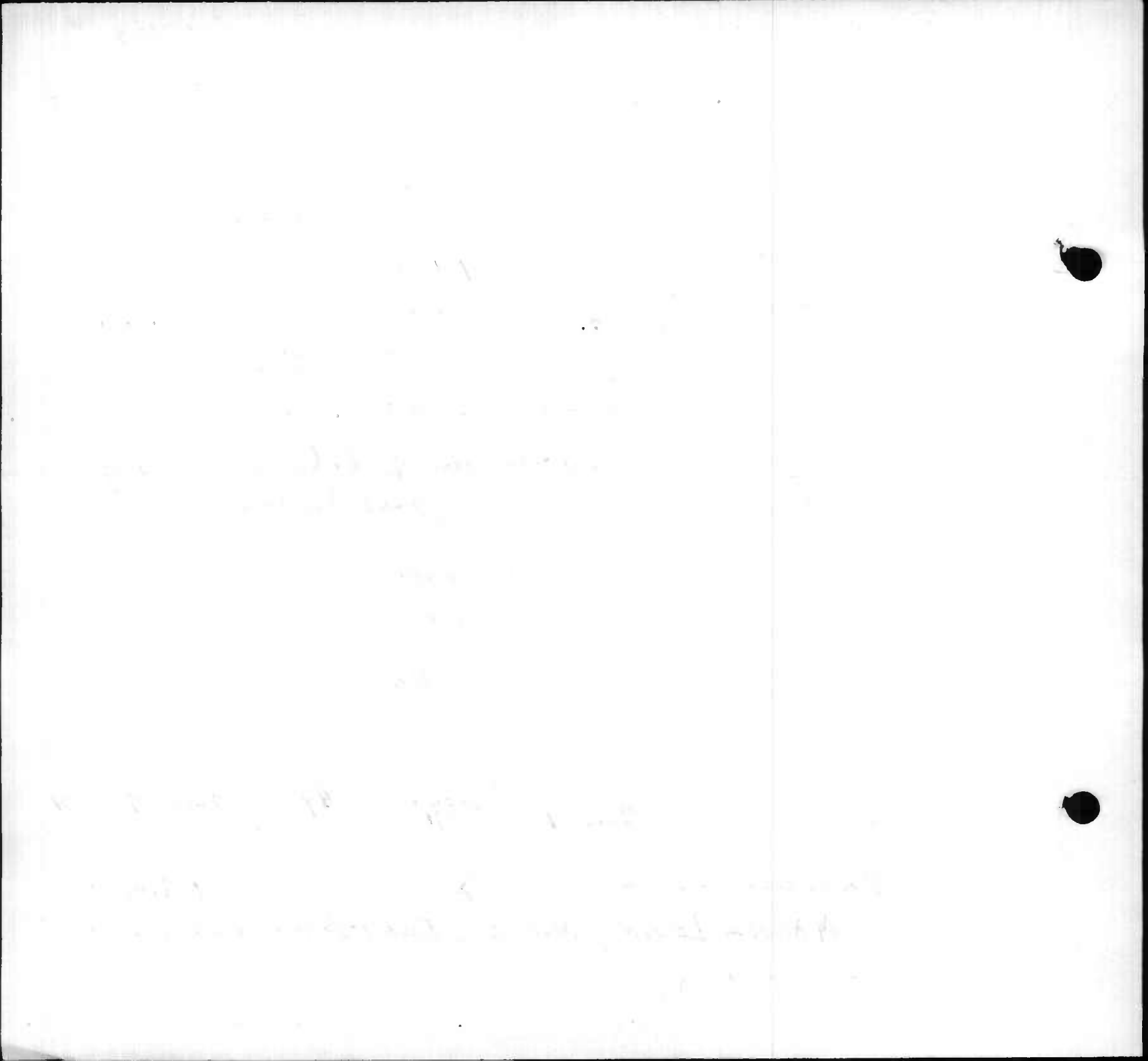
| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                |                                                                                                                                                                                                                                                                                                                                                          |                                             | REG. NO. <u>71 10488</u>                                                        |                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| <u>M-460</u><br><b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <u>Ann Elizabeth M. Miller</u>                                                                                                                                                                                                                                                                                                                                                                                          |                                | <b>2. DATE AND HOUR OF DEATH</b><br><u>November 10, 1971</u> <u>2 40</u> <u>PM</u>                                                                                                                                                                                                                                                                       |                                             |                                                                                 |                                                                                                                       |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location)<br><u>Bon Secour Hospital</u>                                                                                                                                                                                                                                                                                       |                                | <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>2864</u><br><b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>E. STREET AND NUMBER</b><br><u>4218 Vermont Avenue</u> |                                             |                                                                                 |                                                                                                                       |
| <b>5. SEX</b><br><u>Female</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>6. RACE</b><br><u>White</u> | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>                                                                                                                                                                  | <b>8. DATE OF BIRTH</b><br><u>6/28/1891</u> | <b>9. AGE</b> (In years last birthday) <u>80</u>                                | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Secretary</u> |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Secretary</u>                                                                                                                                                                                                                                                                                                                                                                                    |                                | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><u>Veterans Adm.</u>                                                                                                                                                                                                                                                                                         |                                             | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Maryland</u>             | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>                                                                  |
| <b>13. FATHER'S NAME</b><br><u>Kasper J. Miller</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Katherine Becker</u>                                                                                                                                                                                                                                                                                               |                                             |                                                                                 |                                                                                                                       |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                                                                                                                                                              |                                | <b>16. SOCIAL SECURITY NO.</b><br><u>220-38-7527</u>                                                                                                                                                                                                                                                                                                     |                                             | <b>17. INFORMANT ADDRESS</b><br><u>Mr. Bernard Zeitler 4216 Vermont Ave.</u>    |                                                                                                                       |
| <b>18. CAUSE OF DEATH</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>Heart failure.</u><br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |                                |                                                                                                                                                                                                                                                                                                                                                          |                                             |                                                                                 |                                                                                                                       |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>                                                                                                                                                                                                                                                                                                                                                      |                                |                                                                                                                                                                                                                                                                                                                                                          |                                             |                                                                                 |                                                                                                                       |
| <b>19A. DATE OF OPERATION</b><br><u>0</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>                                                                                                                                                                                                                                                                                                  |                                             | <b>20A. AUTOPSY?</b> (Yes or No)<br><u>No</u>                                   |                                                                                                                       |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                  |                                | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                          |                                             | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) |                                                                                                                       |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                         |                                             | <b>21F. HOW DID INJURY OCCUR?</b>                                               |                                                                                                                       |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov. 9</u> <u>1971</u> <b>to</b> <u>Nov. 10</u> <u>1971</u><br><b>that (I) (we) last saw the deceased alive on</b> <u>Nov. 10</u> <u>1971</u> <b>and that in (my) (our) opinion death occurred on the date</b><br><b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>                                                                                                       |                                |                                                                                                                                                                                                                                                                                                                                                          |                                             |                                                                                 |                                                                                                                       |
| <b>23A. SIGNATURE</b><br><u>Bandith Suttiratanana MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                |                                                                                                                                                                                                                                                                                                                                                          |                                             | <b>23B. DATE SIGNED</b><br><u>11-10-71</u>                                      |                                                                                                                       |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br><u>BANDITH SUTTIRATANA MD.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                |                                                                                                                                                                                                                                                                                                                                                          |                                             | <b>23D. ADDRESS</b><br><u>Bon Secour Hospital Baltimore Md.</u>                 |                                                                                                                       |
| <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                | <b>24B. DATE</b><br><u>11/12/1971</u>                                                                                                                                                                                                                                                                                                                    |                                             | <b>24C. NAME OF CEMETERY OR CREMATORY</b><br><u>Loudon Park Cemetery</u>        |                                                                                                                       |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br><u>Baltimore, Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                                                        |                                | <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><u>NOV 15 1971</u>                                                                                                                                                                                                                                                                                             |                                             |                                                                                 |                                                                                                                       |
| <b>25B. NAME OF REGISTRAR</b><br><u>Robert E. Fisher, MD.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                | <b>25C. FUNERAL DIRECTOR ADDRESS</b><br><u>G. Truman Schwab 3512 Frederick Ave</u>                                                                                                                                                                                                                                                                       |                                             |                                                                                 |                                                                                                                       |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                           |                                                                                                                                                                                                                                                                                                                                                                   |                                                       |                                                                                                                                 |                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| <p><b>B-552</b>      <b>71 10489</b></p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;">REG. NO. <b>71 10489</b></p>                                                                                                                                                                                                                                                                                                              |                                           |                                                                                                                                                                                                                                                                                                                                                                   |                                                       |                                                                                                                                 |                                                 |
| <p><b>BIRTH NO.</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                           | <p><b>1. NAME OF DECEASED</b><br/>(Type or Print)</p> <p style="text-align: center;"><u>Benjamin H. Romans</u></p>                                                                                                                                                                                                                                                |                                                       | <p><b>2. DATE AND HOUR OF DEATH</b></p> <p style="text-align: center;"><u>Nov. 9, 1971</u>      <u>3<sup>30</sup> P. M.</u></p> |                                                 |
| <p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>2516 Wilkens Avenue</u></p>                                                                                                                                                                                                                                                                                                                            |                                           | <p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <u>Maryland</u></p> <p>B. COUNTY <u>2005</u></p> <p>C. CITY OR TOWN <u>Baltimore</u></p> <p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>2516 Wilkens Avenue</u></p> |                                                       |                                                                                                                                 |                                                 |
| <p><b>5. SEX</b></p> <p><u>Male</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <p><b>6. RACE</b></p> <p><u>White</u></p> | <p><b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/></p> <p><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>                                                                                                                                                                | <p><b>8. DATE OF BIRTH</b></p> <p><u>2/6/1889</u></p> | <p><b>9. AGE</b> (In years last birthday) <u>82</u></p>                                                                         | <p>If Under 1 Yr. Months: Days: Hours: Min.</p> |
| <p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p> <p><u>Rubber Pourer</u></p>                                                                                                                                                                                                                                                                                                                                                                                                              |                                           | <p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p> <p><u>Pittsburg Plate Glass Co.</u></p>                                                                                                                                                                                                                                                                           |                                                       | <p><b>11. BIRTHPLACE</b> (State or foreign country)</p> <p><u>Maryland</u></p>                                                  |                                                 |
| <p><b>12. CITIZEN OF WHAT COUNTRY?</b></p> <p><u>U.S.A.</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                           | <p><b>13. FATHER'S NAME</b></p> <p><u>Furman Romans</u></p>                                                                                                                                                                                                                                                                                                       |                                                       | <p><b>14. MOTHER'S MAIDEN NAME</b></p> <p><u>Annie Bentley</u></p>                                                              |                                                 |
| <p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><u>No</u></p>                                                                                                                                                                                                                                                                                                                                                                                                            |                                           | <p><b>16. SOCIAL SECURITY NO.</b></p> <p><u>213-10-5478</u></p>                                                                                                                                                                                                                                                                                                   |                                                       | <p><b>17. INFORMANT</b> ADDRESS</p> <p><u>Mrs Jessie J. Romans 2516 Wilkens Ave.</u></p>                                        |                                                 |
| <p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p><u>153.81</u></p> <p><b>CAUSE OF DEATH</b></p> <p><u>Carcinoma of Colon</u></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Metastases</u></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <u>None</u></p> <p>(C) <u>None</u></p> <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p> <p><u>2 years</u></p> |                                           |                                                                                                                                                                                                                                                                                                                                                                   |                                                       |                                                                                                                                 |                                                 |
| <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><u>None</u></p>                                                                                                                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                                                                                                                                                                                   |                                                       |                                                                                                                                 |                                                 |
| <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b></p> <p><u>None</u></p>                                                                                                                                                                                                                                                                                                                                                                                  |                                           |                                                                                                                                                                                                                                                                                                                                                                   |                                                       |                                                                                                                                 |                                                 |
| <p><b>19A. DATE OF OPERATION</b></p> <p><u>None</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                           | <p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p> <p><u>None</u></p>                                                                                                                                                                                                                                                                                 |                                                       | <p><b>20A. AUTOPSY?</b> (Yes or No)</p> <p><u>No</u></p>                                                                        |                                                 |
| <p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p> <p><u>None</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                           |                                                                                                                                                                                                                                                                                                                                                                   |                                                       |                                                                                                                                 |                                                 |
| <p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p> <p><input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                |                                           | <p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p><u>None</u></p>                                                                                                                                                                                                                                         |                                                       | <p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p> <p><u>None</u></p>                       |                                                 |
| <p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)</p> <p>(APPROX.)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                           | <p><b>21E. INJURY OCCURRED</b></p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>                                                                                                                                                                                                                                       |                                                       | <p><b>21F. HOW DID INJURY OCCUR?</b></p> <p><u>None</u></p>                                                                     |                                                 |
| <p><b>22. I certify that (I) (this hospital) attended the deceased from <u>Nov 1 1969</u> to <u>Nov 9 1971</u> that (I) (we) lost saw the deceased alive on <u>Nov 9 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>                                                                                                                                                                                                     |                                           |                                                                                                                                                                                                                                                                                                                                                                   |                                                       |                                                                                                                                 |                                                 |
| <p><b>23A. SIGNATURE</b></p> <p><u>Manuel Levin</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                           | <p><b>23B. DATE SIGNED</b></p> <p><u>11/10/71</u></p>                                                                                                                                                                                                                                                                                                             |                                                       | <p><b>23C. PHYSICIAN'S NAME</b> (Type)</p> <p><u>MANUEL LEVIN M.D.</u></p>                                                      |                                                 |
| <p><b>23D. ADDRESS</b></p> <p><u>6161 Park Hyb Ave, Balto Md 21245</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                                                                                                                                                                                   |                                                       |                                                                                                                                 |                                                 |
| <p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b></p> <p><u>Burial</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                           | <p><b>24B. DATE</b></p> <p><u>11/12/1971</u></p>                                                                                                                                                                                                                                                                                                                  |                                                       | <p><b>24C. NAME OF CEMETERY or CREMATORY</b></p> <p><u>Loudon Park Cemetery</u></p>                                             |                                                 |
| <p><b>24D. LOCATION</b> (City, town, or county) (State)</p> <p><u>Baltimore, Maryland</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                           |                                                                                                                                                                                                                                                                                                                                                                   |                                                       |                                                                                                                                 |                                                 |
| <p><b>25A. DATE REC'D BY HEALTH DEPT.</b></p> <p><u>NOV 15 1971</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                           | <p><b>25B. NAME OF REGISTRAR</b></p> <p><u>James E. Gable, M.D.</u></p>                                                                                                                                                                                                                                                                                           |                                                       | <p><b>25C. FUNERAL DIRECTOR</b> ADDRESS</p> <p><u>G. Truman Schwab 3512 Frederick Ave.</u></p>                                  |                                                 |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                          |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                          |  | REG. NO. <b>71 10490</b>                                                                                                 |  |
| W-425 <b>71 10490</b>                                                                                                                                                                                                                                                                                                                                     |  | CERTIFICATE OF DEATH                                                                                                     |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                 |  | 2. DATE AND HOUR OF DEATH                                                                                                |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>SYLVIA WILSON</b>                                                                                                                                                                                                                                                                                               |  | <b>11/8/71</b> <b>5:32 A.M.</b>                                                                                          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                    |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                    |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>JOHNS HOPKINS HOSPITAL</b>                                                                                                                                                                                                                |  | A. STATE <b>MD.</b> B. COUNTY <b>CECIL</b>                                                                               |  |
| 5. SEX <b>F</b> 6. RACE <b>W W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                               |  | C. CITY OR TOWN <b>ELKTON</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 8. DATE OF BIRTH <b>7/31/18</b> 9. AGE (in years last birthday) <b>53</b>                                                                                                                                                                                                                                                                                 |  | E. STREET AND NUMBER <b>P.O. Box 1003</b>                                                                                |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>                                                                                                                                                                                                                                              |  | 11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>                                                            |  |
| 10B. KIND OF BUSINESS OR INDUSTRY <b>--</b>                                                                                                                                                                                                                                                                                                               |  | 12. CITIZEN OF WHAT COUNTRY <b>USA</b>                                                                                   |  |
| 13. FATHER'S NAME <b>HOLLADA, HENRY</b>                                                                                                                                                                                                                                                                                                                   |  | 14. MOTHER'S MAIDEN NAME <b>LEE, ESTIE</b>                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>                                                                                                                                                                                                                                        |  | 16. SOCIAL SECURITY NO.                                                                                                  |  |
| 17. INFORMANT <b>Charles R. Wilson, Elkton, Md.</b>                                                                                                                                                                                                                                                                                                       |  | ADDRESS                                                                                                                  |  |
| 18. <b>5717 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                             |  |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                               |  | <b>6 HRS.</b>                                                                                                            |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                         |  | <b>HEMORRHAGE</b>                                                                                                        |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                                 |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                      |  |
| <b>ESOPHAGEAL VARICES</b>                                                                                                                                                                                                                                                                                                                                 |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                      |  |
| <b>HEPATITIS, CIRRHOSIS OF LIVER</b>                                                                                                                                                                                                                                                                                                                      |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                      |  |
| <b>10 DAYS, ?</b>                                                                                                                                                                                                                                                                                                                                         |  | <b>10 DAYS, ?</b>                                                                                                        |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                          |  | <b>RENAL FAILURE, HEPATIC ENCEPHALOPATHY</b>                                                                             |  |
| <b>10 DAYS - 4 DAYS</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                          |  |
| 19A. DATE OF OPERATION <b>2</b>                                                                                                                                                                                                                                                                                                                           |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                         |  |
| 20A. AUTOPSY? (Yes or No) <b>YES - PARTIAL</b>                                                                                                                                                                                                                                                                                                            |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>                                           |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                            |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                 |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                  |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                          |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                    |  | 21F. HOW DID INJURY OCCUR?                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>NOV 1</b> 19 <b>71</b> to <b>NOV 8</b> 19 <b>71</b> that (I) (we) lost saw the deceased alive on <b>NOV. 8</b> 19 <b>71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                          |  |
| 23A. SIGNATURE <b>Bruce M. Greene MD</b>                                                                                                                                                                                                                                                                                                                  |  | 23B. DATE SIGNED <b>11-8-71</b>                                                                                          |  |
| 23C. PHYSICIAN'S NAME (Type) <b>BRUCE M. GREENE</b>                                                                                                                                                                                                                                                                                                       |  | 23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL BALTIMORE MD</b>                                                                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                    |  | 24B. DATE <b>11/11/71</b>                                                                                                |  |
| 24C. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Park</b>                                                                                                                                                                                                                                                                                      |  | 24D. LOCATION (City, town, or county) (State) <b>Elkton, Maryland</b>                                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT <b>NOV 15 1971</b>                                                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR <b>Ralph E. Nicks</b>                                                                             |  |
| 25C. FUNERAL DIRECTOR <b>Ralph E. Nicks</b>                                                                                                                                                                                                                                                                                                               |  | ADDRESS <b>Hicks Home for Funerals, Elkton, Md.</b>                                                                      |  |

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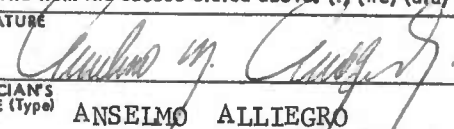
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                | REG. NO. <span style="float: right;">71 10491</span>                     |                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. <span style="float: right;">K-246 71 10491</span>                                                                                                                                                                                                                                                                                                                                        |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>ERNEST Lemuel (KESSLER) KESLER</b>                                                                                |                                                                                                                                                                                                                                                                                                                                | 2. DATE AND HOUR OF DEATH<br><b>11-10-71</b>                             |                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>37 MERCY HOSPITAL</b>                                                                                                                                                                                                |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b><br>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1618 S. Manover St.</b> |                                                                          |                                                        |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                              | 6. RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Mar. 4, 1906</b>                                                                                                                                                                                                                                                                                        | 9. AGE (In years last birthday)<br><b>65</b>                             | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>                                                                                                                                                                                                                                                                                      |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Carpenter</b>                                                                                                       | 11. BIRTHPLACE (State or foreign country)<br><b>Magnolia, W. Va.</b>                                                                                                                                                                                                                                                           |                                                                          | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>             |
| 13. FATHER'S NAME<br><b>James Kesler</b>                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>Florence Rockwell</b>                                                                                                                                                                                                                                                                           |                                                                          |                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                                                              |                         | 16. SOCIAL SECURITY NO.<br><b>705-05-9241</b>                                                                                                               | 17. INFORMANT ADDRESS<br><b>Mrs. Dorothy Kesler, Cumberland, Md. Wife</b>                                                                                                                                                                                                                                                      |                                                                          |                                                        |
| 18. <b>410.9 I</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Germany Klebsiella</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                   |                                                                          |                                                        |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                |                                                                          |                                                        |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                             |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                                                | 20A. AUTOPSY? (Yes or No)                                                |                                                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)                                                                                                                                                                                                                                                                                                              |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                                                | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                        |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                                      |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                                                                                                                                                | 21F. HOW DID INJURY OCCUR?                                               |                                                        |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.                                                                                   |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                |                                                                          |                                                        |
| 23A. SIGNATURE<br>                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             | 23B. DATE SIGNED<br><b>11/10/71</b>                                                                                                                                                                                                                                                                                            |                                                                          |                                                        |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ANSELMO ALLIEGRO</b>                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             | 23D. ADDRESS<br><b>8155 LOCH RAVEN BLVD.</b>                                                                                                                                                                                                                                                                                   |                                                                          |                                                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                          |                         | 24B. DATE<br><b>11-13-71</b>                                                                                                                                |                                                                                                                                                                                                                                                                                                                                | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Camp Hill Cemetery</b>          |                                                        |
| 24D. LOCATION<br><b>Paw Paw, W. Va.</b>                                                                                                                                                                                                                                                                                                                                                            |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 15 1971</b>                                                                                                       |                                                                                                                                                                                                                                                                                                                                |                                                                          |                                                        |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taber, M.D.</b>                                                                                                                                                                                                                                                                                                                                             |                         | 25C. FUNERAL DIRECTOR ADDRESS<br><b>James F. Scarpelli, Cumberland, Md.</b>                                                                                 |                                                                                                                                                                                                                                                                                                                                |                                                                          |                                                        |

Office

Carroll

Samuel, W. Va.

Richardson

705-05-1241

Mrs. Dorothy Taylor

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                    | X                                                                                                                                                                                                                                                                                                                               |                                              | 71 10492                                                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------------------------------|--|
| BIRTH NO. <u>S-354</u> <u>71 10492</u>                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                    | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                            |                                              | REG. NO. <u>71 10492</u>                                                              |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>BABY GIRL STANLEY</u>                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                    | 2. DATE AND HOUR OF DEATH<br><u>NOV 4 7 18 15 A.M.</u>                                                                                                                                                                                                                                                                          |                                              |                                                                                       |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>JOHNS HOPKINS HOSPITAL</u><br><u>33</u>                                                                                                                                                             |                         |                                                                                                                                                             |                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>Nebraska</u><br>C. CITY OR TOWN <u>Cambridge</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>640 Washington Street</u> |                                              |                                                                                       |  |
| 5. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                                                           | 6. RACE<br><u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11/2/71</u> |                                                                                                                                                                                                                                                                                                                                 | 9. AGE (In years last birthday)<br><u>44</u> | If Under 1 Yr. Months: <u>1</u> Days: <u>44</u> If Under 24 Hrs. Hour: <u>15</u> Min. |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                       |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Cambridge Hospital</u>                                                                                                                                                                                                                                                          |                                              | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                            |  |
| 13. FATHER'S NAME<br><u>Rudolph Camper</u>                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                    | 14. MOTHER'S M maiden NAME<br><u>Carolyn Stanley</u>                                                                                                                                                                                                                                                                            |                                              |                                                                                       |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                                             |                         | 16. SOCIAL SECURITY NO.<br><u>No</u>                                                                                                                        |                                    | 17. INFORMANT ADDRESS<br><u>Carlton Stanley 629 Wash. St. Camb., Md.</u>                                                                                                                                                                                                                                                        |                                              |                                                                                       |  |
| 18. <u>746.81</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                         |                         |                                                                                                                                                             |                                    | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <u>CARDIORESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <u>SEVERE CONGESTIVE FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <u>HYPOTENSIVE LEFT HEART SYNDROME BIRTH</u>                                                                                         |                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>14 HRS</u><br><u>14 HR</u>         |  |
|                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                    |                                                                                                                                                                                                                                                                                                                                 |                                              |                                                                                       |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                    |                                                                                                                                                                                                                                                                                                                                 |                                              |                                                                                       |  |
| 19A. DATE OF OPERATION<br><u>2</u>                                                                                                                                                                                                                                                                                                                                                |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                    | 20A. AUTOPSY? (Yes or No)<br><u>Yes</u>                                                                                                                                                                                                                                                                                         |                                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><u>No</u>     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                    |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                        |                                              |                                                                                       |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                                                                                                                                                                                                                                                                                      |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                    | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                      |                                              |                                                                                       |  |
| 22. I certify that (1) <u>this hospital</u> attended the deceased, from <u>12 MID 11/4</u> 19 <u>71</u> to <u>12/4</u> 19 <u>71</u> that (1) <u>we</u> last saw the deceased alive on <u>11/4</u> 19 <u>71</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>We</u> (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                    |                                                                                                                                                                                                                                                                                                                                 |                                              |                                                                                       |  |
| 23A. SIGNATURE<br><u>Basil John Zitelli MD</u>                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |                                    | 23B. DATE SIGNED<br><u>11/4/71</u>                                                                                                                                                                                                                                                                                              |                                              | 23C. PHYSICIAN'S NAME (Type)<br><u>BASIL JOHN ZITELLI MD</u>                          |  |
| 23D. ADDRESS<br><u>The Johns Hopkins Hospital</u>                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                    | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                       |                                              |                                                                                       |  |
| 24B. DATE<br><u>11/6/71</u>                                                                                                                                                                                                                                                                                                                                                       |                         | 24C. NAME OF CEMETERY or CREMATORY<br><u>Bucktown Cemetery</u>                                                                                              |                                    | 24D. LOCATION (City, town, or county) (State)<br><u>Bucktown Dor. Md.</u>                                                                                                                                                                                                                                                       |                                              |                                                                                       |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>NOV 15 1971</u>                                                                                                                                                                                                                                                                                                                             |                         | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, M.D.</u>                                                                                                     |                                    | 25C. FUNERAL DIRECTOR ADDRESS<br><u>Lewis H. Boardley 603 Wash. St. 21613</u>                                                                                                                                                                                                                                                   |                                              |                                                                                       |  |

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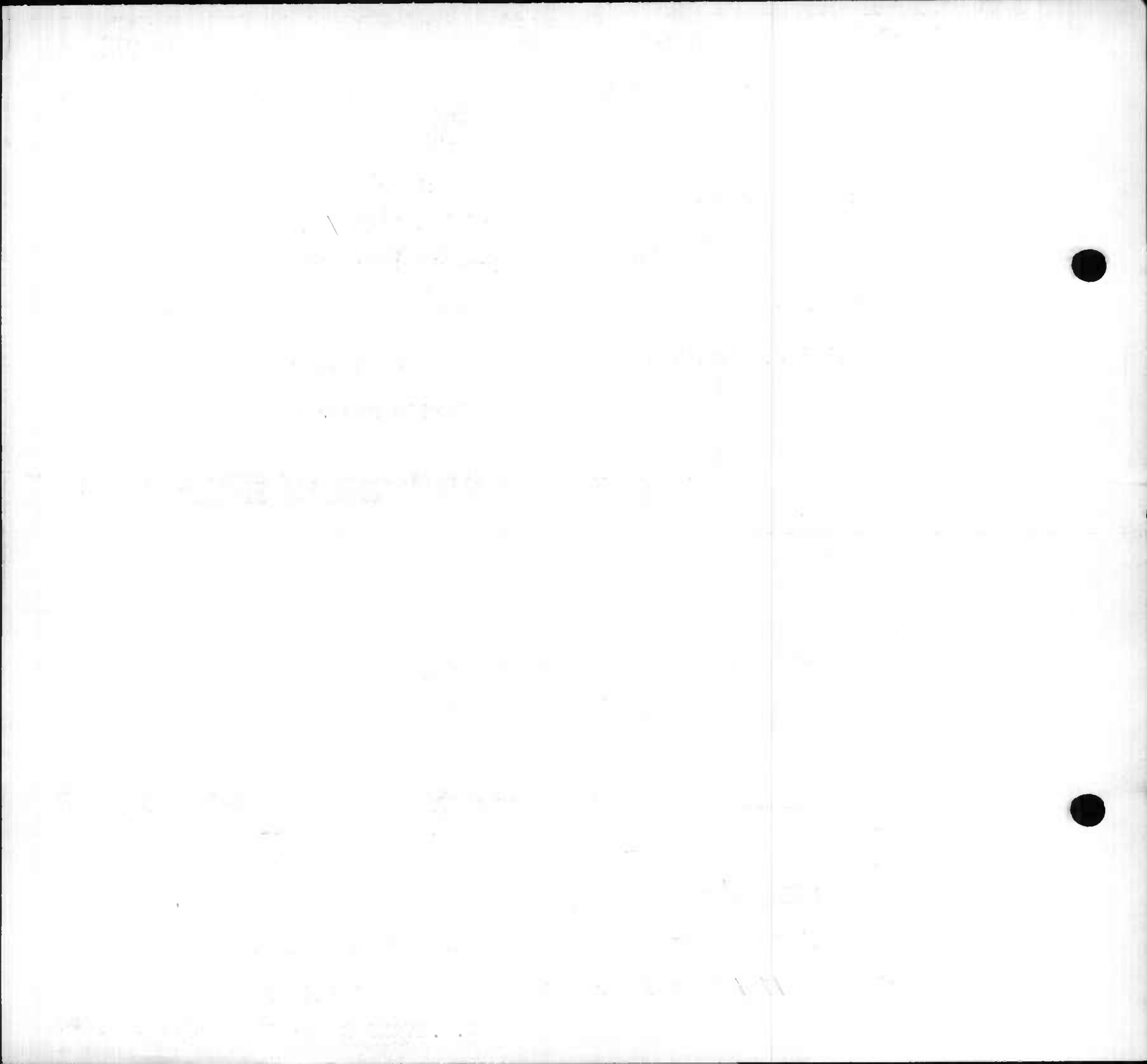
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                  |  | REG. NO. <u>71 10493</u>                                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|
| <p>BIRTH NO. <u>8-550</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>MARY E SHANNON</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | <p>2. DATE AND HOUR OF DEATH <u>Nov 10 1971</u> <u>1</u> <u>2</u> <u>P</u> <u>M.</u></p>                                                                                                                                                                                                                                         |  |                                                                                       |  |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>00</u> <u>504 E 38th St</u></p>                                                                                                                                                                                                                                                                                                                                                        |  | <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <u>Md</u> B. COUNTY <u>901</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>504 E 38th /St</u></p> |  |                                                                                       |  |
| <p>5. SEX <u>F</u> 6. RACE <u>W</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>                                                                                                                                                                  |  | <p>8. DATE OF BIRTH <u>June 13 1891</u> 9. AGE (In years last birthday) <u>80</u></p> |  |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | <p>10B. KIND OF BUSINESS OR INDUSTRY</p>                                                                                                                                                                                                                                                                                         |  | <p>11. BIRTHPLACE (State or foreign country) <u>Md</u></p>                            |  |
| <p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | <p>13. FATHER'S NAME <u>Daniel J. Shanahan</u></p>                                                                                                                                                                                                                                                                               |  |                                                                                       |  |
| <p>14. MOTHER'S MAIDEN NAME <u>Mary E Coen</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>                                                                                                                                                                                                        |  |                                                                                       |  |
| <p>16. SOCIAL SECURITY NO.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | <p>17. INFORMANT ADDRESS <u>Family records</u></p>                                                                                                                                                                                                                                                                               |  |                                                                                       |  |
| <p>18. <u>412.4</u> I CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <u>Arteriosclerotic cardio-vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>5 yrs.</u></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p> |  |                                                                                                                                                                                                                                                                                                                                  |  |                                                                                       |  |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                  |  |                                                                                       |  |
| <p>19A. DATE OF OPERATION</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>                                                                                                                                                                                                                                                                          |  | <p>20A. AUTOPSY? (Yes or No) <u>No</u></p>                                            |  |
| <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>                                                                                                                                                                                                            |  |                                                                                       |  |
| <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>                                                                                                                                                                                                                                                  |  |                                                                                       |  |
| <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>                                                                                                                                                                                                                    |  | <p>21F. HOW DID INJURY OCCUR?</p>                                                     |  |
| <p>22. I certify that (I) (<del>this hospital</del>) attended the deceased from <u>September 1961</u> to <u>November 10, 1971</u> that (I) (<del>we</del>) last saw the deceased alive on <u>November 10, 1971</u> and that in (my) (<del>our</del>) opinion death occurred on the date and hour and from the causes stated above. (I) (<del>we</del>) (<del>did</del>) (<del>did not</del>) view the body after death.</p>                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                  |  |                                                                                       |  |
| <p>23A. SIGNATURE <u>Lloyd E. Saylor MD</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | <p>23B. DATE SIGNED <u>Nov. 12, 1971</u></p>                                                                                                                                                                                                                                                                                     |  | <p>23C. PHYSICIAN'S NAME (Type) <u>Lloyd Saylor MD</u></p>                            |  |
| <p>23D. ADDRESS <u>3902 Greenmount ave</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | <p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>                                                                                                                                                                                                                                                                    |  |                                                                                       |  |
| <p>24B. DATE <u>11/13/71</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | <p>24C. NAME of CEMETERY or CREMATORY <u>Cathedral Cem</u></p>                                                                                                                                                                                                                                                                   |  | <p>24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u></p>              |  |
| <p>25A. DATE REC'D BY HEALTH DEPT. <u>NOV 15 1971</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | <p>25B. NAME OF REGISTRAR <u>Robert E. Saylor, M.D.</u></p>                                                                                                                                                                                                                                                                      |  | <p>25C. FUNERAL DIRECTOR ADDRESS <u>C.F. EVANS &amp; SON 8802 Harford road</u></p>    |  |

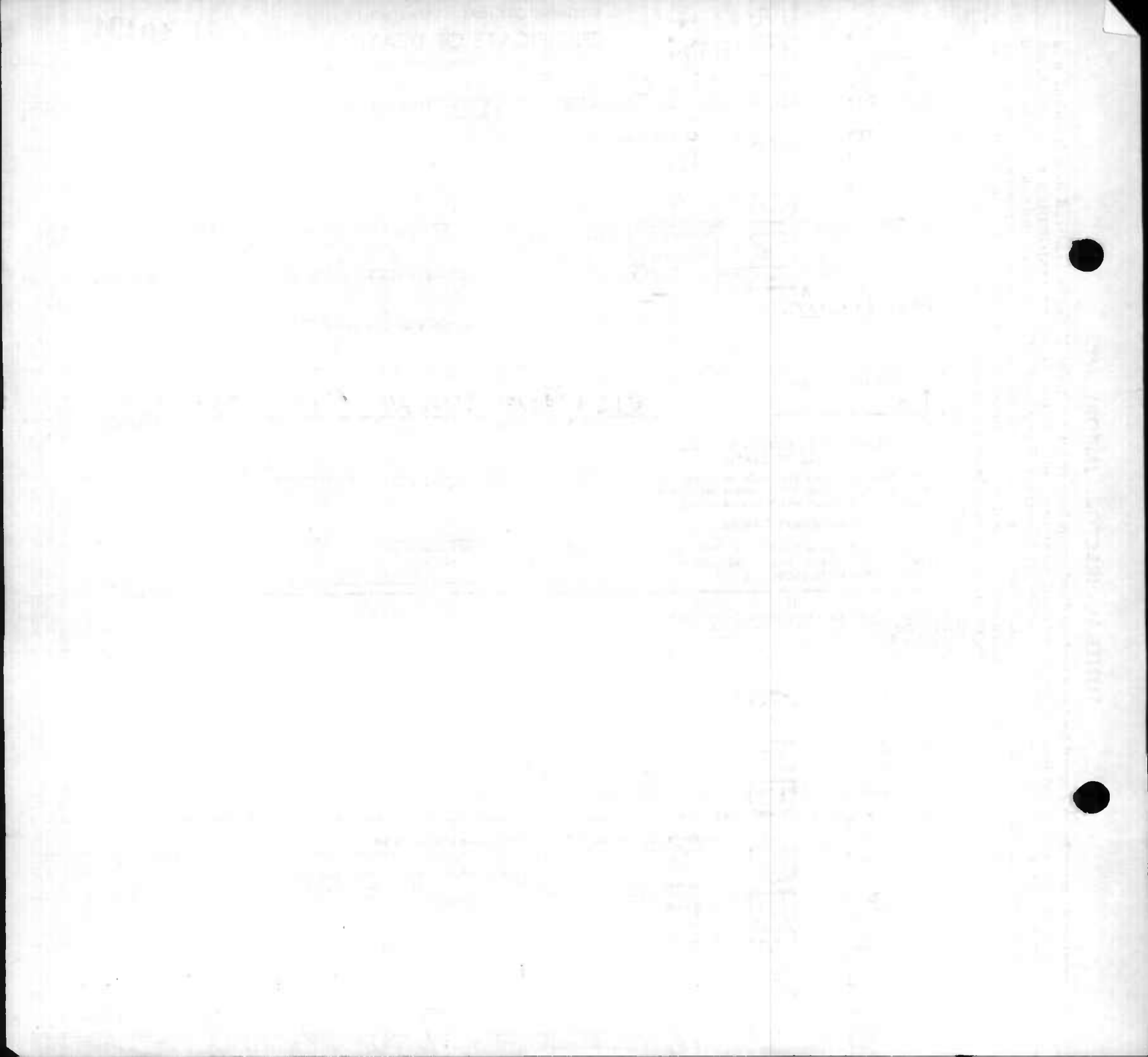




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

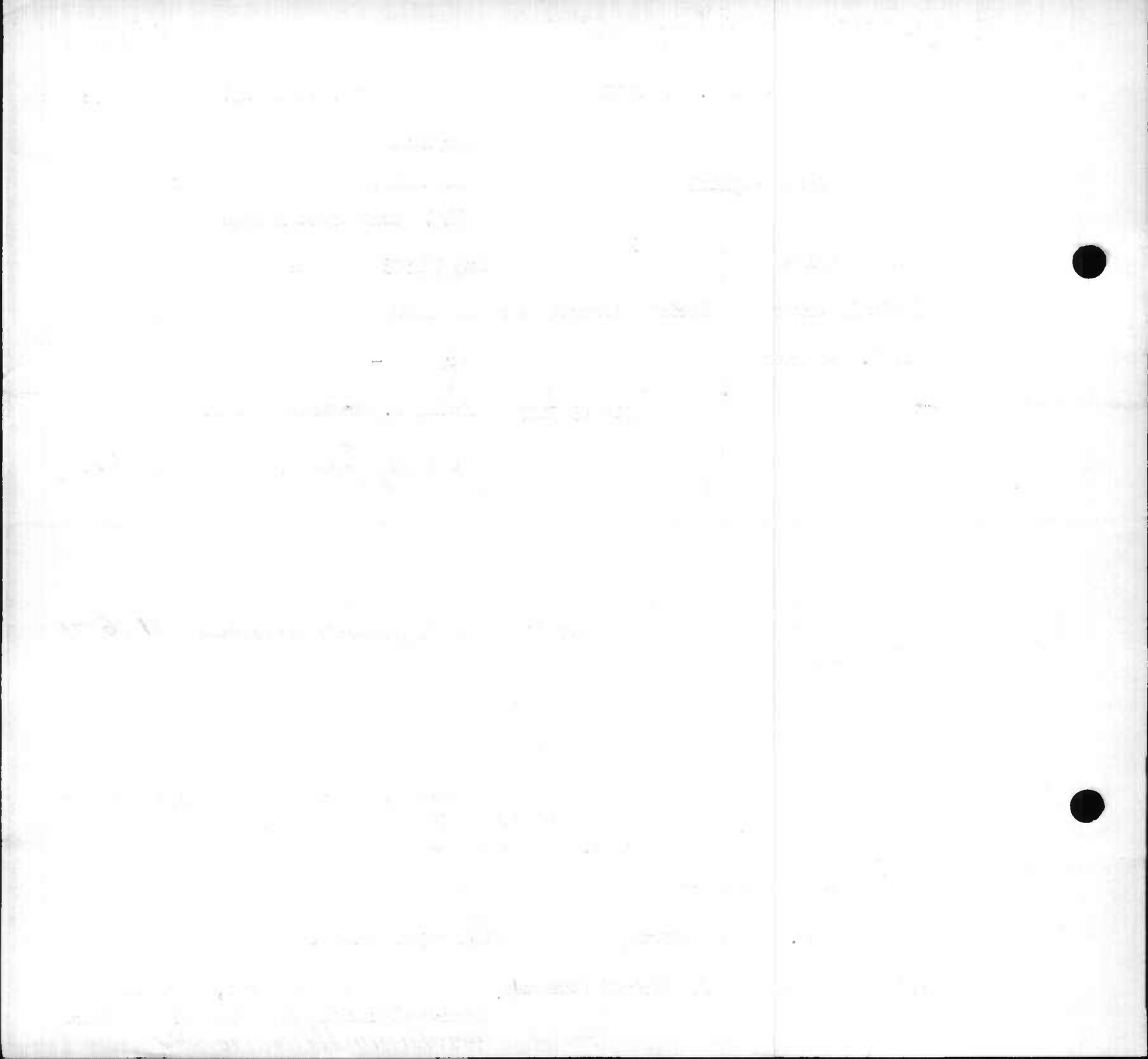
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |                                                                                                                                      | REG. NO. <b>71 10484</b>                                                             |                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| BIRTH NO. <b>71 10494</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |                                                                                                                                      | CERTIFICATE OF DEATH                                                                 |                                                                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARGARET C MOLES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>11-10-71 5:40pm</b>                                                                                  |                                                                                      |                                                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b><br>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MD</b><br>B. COUNTY <b>1307</b> |                                                                                      |                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     |                                                                                                                                                             | C. CITY OR TOWN <b>BALTIMORE</b>                                                                                                     |                                                                                      | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     |                                                                                                                                                             | E. STREET AND NUMBER<br><b>4106 FALLS ROAD</b>                                                                                       |                                                                                      |                                                                                               |
| 5. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                      | 8. DATE OF BIRTH<br><b>3-3-84</b>                                                    | 9. AGE (In years last birthday) <b>87</b>                                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                                                                                                               |                                                                                                                                      | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                         |                                                                                               |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>AMERICAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     | 13. FATHER'S NAME<br><b>BENJAMIN CROWTHER</b>                                                                                                               |                                                                                                                                      |                                                                                      |                                                                                               |
| 14. MOTHER'S MAIDEN NAME<br><b>CECELIA BROWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     | 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                       |                                                                                                                                      |                                                                                      |                                                                                               |
| 16. SOCIAL SECURITY NO.<br><b>212 528218</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     | 17. INFORMANT<br><b>Dorothy Parks 3800 Falls Rd</b>                                                                                                         |                                                                                                                                      |                                                                                      |                                                                                               |
| 18. <b>250.91</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,<br><br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><br>19A. DATE OF OPERATION<br><b>0</b> |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                      | 20A. AUTOPSY? (Yes or No)                                                            |                                                                                               |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     | (A) IMMEDIATE CAUSE - <b>CARDIO-RESPIRATORY</b><br>DUE TO, OR AS A CONSEQUENCE OF: <b>ARRES</b>                                                             |                                                                                                                                      |                                                                                      |                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     | (B) <b>DIABETES - MYOCARDIAL</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                         |                                                                                                                                      |                                                                                      |                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     | (C) <b>INFARCTION</b>                                                                                                                                       |                                                                                                                                      |                                                                                      |                                                                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)             |                                                                                               |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                      | 21F. HOW DID INJURY OCCUR?                                                           |                                                                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11-5</b> 19 <b>71</b> to <b>11-10</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>11-10</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                  |                     |                                                                                                                                                             |                                                                                                                                      |                                                                                      |                                                                                               |
| 23A. SIGNATURE<br><b>Juan M. Calderon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     | 23B. DATE SIGNED<br><b>11-10-71</b>                                                                                                                         |                                                                                                                                      | 23C. PHYSICIAN'S NAME (Type)<br><b>JUAN M. CALDERON M.D.</b>                         |                                                                                               |
| 23D. ADDRESS<br><b>UHH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                   |                                                                                                                                      |                                                                                      |                                                                                               |
| 24B. DATE<br><b>15 Nov 71</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     | 24C. NAME OF CEMETERY or CREMATORY<br><b>Woodlawn Cemetery</b>                                                                                              |                                                                                                                                      | 24D. LOCATION (City, town, or county) (State)<br><b>Woodlawn, Balto Co, Maryland</b> |                                                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 15 1971</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>                                                                                                     |                                                                                                                                      | 25C. FUNERAL DIRECTOR<br><b>Burgess Funeral Home Baltimore Maryland</b>              |                                                                                               |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                                                                                                           |                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-----------------------------------------------------------------------------------------------------------|------------------|
| <p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         | <p>REG. NO. <b>71 10495</b></p>                                                                           |                  |
| <p><b>G-635</b>      <b>71 10495</b></p> <p>BIRTH NO.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |         | <p>1. NAME OF DECEASED<br/>(Type or Print)</p> <p style="text-align: center;"><b>JOHN D. GARDINER</b></p> |                  |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p style="font-size: 2em; margin-left: 10px;"><b>42</b>      <b>Sinai Hospital</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                 |         | <p>2. DATE AND HOUR OF DEATH</p> <p style="text-align: right;"><b>November 10 1971      9:10 P.M.</b></p> |                  |
| <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE      <b>Maryland</b></p> <p>C. CITY OR TOWN      <b>Baltimore</b></p> <p>D. INSIDE CITY LIMITS?      YES <input checked="" type="checkbox"/>      NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER      <b>4107 Buena Vista Avenue</b></p>                                                                                                                                                                                                                                                                                                                            |         | <p><b>1348</b></p>                                                                                        |                  |
| 5. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                     | 8. DATE OF BIRTH |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | White   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                        | Aug 7 1903       |
| 9. AGE (In years last birthday)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |         | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                |                  |
| 68                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |         | Clerical Worker                                                                                           |                  |
| 11. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |         | 12. CITIZEN OF WHAT COUNTRY?                                                                              |                  |
| New York                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |         | USA                                                                                                       |                  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         | 14. MOTHER'S MAIDEN NAME                                                                                  |                  |
| Asa B. Gardiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |         | Mary -                                                                                                    |                  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |         | 16. SOCIAL SECURITY NO.                                                                                   |                  |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |         | 220 05 3119                                                                                               |                  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |         | ADDRESS                                                                                                   |                  |
| Thelma S. Gardiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |         | same                                                                                                      |                  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                              |                  |
| <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">(A) IMMEDIATE CAUSE</p> <p style="text-align: center;">DUE TO, OR AS A CONSEQUENCE OF:</p> <p style="text-align: center;">CORONARY THROMBOSIS</p> <p style="text-align: center;">(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p style="text-align: center;">(C) DUE TO, OR AS A CONSEQUENCE OF:</p> <p style="text-align: center;">DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> |         | <p style="text-align: center;">Sudden</p>                                                                 |                  |
| <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |         | <p style="text-align: center;">acute lower respiratory infection</p>                                      |                  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |                  |
| 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |         | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                      |                  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |         | 21D. TIME OF INJURY (APPROX.)                                                                             |                  |
| 21E. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |         | 21F. HOW DID INJURY OCCUR?                                                                                |                  |
| White <input type="checkbox"/> Not White <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         | Work <input type="checkbox"/> At Work <input type="checkbox"/>                                            |                  |
| <p>22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 6 1971</b> to <b>Nov. 10 1971</b> that (I) (we) last saw the deceased alive on <b>Nov. 10 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>                                                                                                                                                                                                                                                                                                                                          |         |                                                                                                           |                  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         | 23B. DATE SIGNED                                                                                          |                  |
| <p style="text-align: center;"><i>Reuben Hoffman</i></p> <p>Dr. Reuben Hoffman</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |         | <p style="text-align: center;"><b>11-12-71</b></p>                                                        |                  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |         | 23D. ADDRESS                                                                                              |                  |
| Dr. Reuben Hoffman                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |         | 846 W 36th Street                                                                                         |                  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |         | 24B. DATE                                                                                                 |                  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         | 13 Nov 71                                                                                                 |                  |
| 24C. NAME OF CEMETERY or CREMATORY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |         | 24D. LOCATION (City, town, or county) (State)                                                             |                  |
| Parkwood Cemetery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         | Taylor Avenue, Bal to Md                                                                                  |                  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |         | 25B. NAME OF REGISTRAR                                                                                    |                  |
| NOV 15 1971                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |         | Robert E. Taylor, M.D.                                                                                    |                  |
| 25C. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         | ADDRESS                                                                                                   |                  |
| Burgess Funeral Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |         | Baltimore Maryland                                                                                        |                  |
| <p>By: <i>Walter H. Burgess</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                                                           |                  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                     |  |                                                                                                                                                       |  | REG. NO. <span style="font-size: 1.2em;">71 10496</span>                                                                                                                                                                                                                                                                                                                                                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| B-240 71 10496                                                                                                                       |  |                                                                                                                                                       |  | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">ANNIE C. BOSWELL</span>                                       |  | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.2em;">Fri. Nov. 12, 1971 12:05 A.M.</span>                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                               |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><span style="font-size: 1.2em;">3001 S. HANOVER ST. BALTIMORE MD 21230</span>                |  | A. STATE<br><span style="font-size: 1.2em;">Maryland</span>                                                                                           |  | B. COUNTY<br><span style="font-size: 1.2em;">2301</span>                                                                                                                                                                                                                                                                                                                                                                                               |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                 |  | C. CITY OR TOWN<br><span style="font-size: 1.2em;">Baltimore 21230</span>                                                                             |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                          |  |
| 5. SEX<br><span style="font-size: 1.2em;">Female</span>                                                                              |  | 6. RACE<br><span style="font-size: 1.2em;">White</span>                                                                                               |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                            |  |
| 8. DATE OF BIRTH<br><span style="font-size: 1.2em;">Sept. 2, 1889</span>                                                             |  | 9. AGE (In years last birthday)<br><span style="font-size: 1.2em;">82</span>                                                                          |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">Housewife</span>                                                                                                                                                                                                                                                                                                         |  |
| 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">Baltimore, Md.</span>                                   |  | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">U.S.A.</span>                                                                         |  | 13. FATHER'S NAME<br><span style="font-size: 1.2em;">Daniel J. Brady</span>                                                                                                                                                                                                                                                                                                                                                                            |  |
| 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">Mary Foy</span>                                                          |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">No</span> |  | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.2em;">212-07-38718</span>                                                                                                                                                                                                                                                                                                                                                                         |  |
| 17. INFORMANT<br><span style="font-size: 1.2em;">Edward L. Boswell (Son)</span>                                                      |  | 18. ADDRESS<br><span style="font-size: 1.2em;">148 W. Meadow Rd. Baltimore 21230</span>                                                               |  | 19. CAUSE OF DEATH<br><span style="font-size: 1.2em;">CORONARY OCCLUSION</span>                                                                                                                                                                                                                                                                                                                                                                        |  |
| 20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><span style="font-size: 1.2em;">ACUTE CORONARY ATTACK</span>                  |  | 21. DUE TO, OR AS A CONSEQUENCE OF:<br><span style="font-size: 1.2em;">3 DAYS</span>                                                                  |  | 22. DUE TO, OR AS A CONSEQUENCE OF:<br><span style="font-size: 1.2em;">IMMEDIATE</span>                                                                                                                                                                                                                                                                                                                                                                |  |
| 23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  |                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
| 24. DATE OF OPERATION<br><span style="font-size: 1.2em;">NOV 15 1971</span>                                                          |  | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><span style="font-size: 1.2em;">Circumcision</span>                                                |  | 26. AUTOPSY? (Yes or No)<br><span style="font-size: 1.2em;">NO</span>                                                                                                                                                                                                                                                                                                                                                                                  |  |
| 27. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                  |  | 28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><span style="font-size: 1.2em;">Baltimore 21230</span>     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
| 29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                 |  | 30. WHERE DID INJURY OCCUR?<br><span style="font-size: 1.2em;">(If in Baltimore City, give exact location)</span>                                     |  | 31. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
| 32. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)<br><span style="font-size: 1.2em;">NOV 15 1971</span>                       |  | 33. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                 |  | 34. I certify that (I) (the hospital) attended the deceased from <span style="font-size: 1.2em;">NOVEMBER 10, 1971</span> to <span style="font-size: 1.2em;">NOVEMBER 12, 1971</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">November 11, 1971</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |
| 35. SIGNATURE<br><span style="font-size: 1.2em;">Harry Deibel M.D.</span>                                                            |  | 36. DATE SIGNED<br><span style="font-size: 1.2em;">11/13/71</span>                                                                                    |  | 37. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">HARRY DEIBEL M.D.</span>                                                                                                                                                                                                                                                                                                                                                                |  |
| 38. ADDRESS<br><span style="font-size: 1.2em;">1226 S. HANOVER STREET, BALTIMORE, MARYLAND</span>                                    |  | 39. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">Burial</span>                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
| 40. DATE<br><span style="font-size: 1.2em;">Nov. 14, 1971</span>                                                                     |  | 41. NAME OF CEMETERY OR CREMATORY<br><span style="font-size: 1.2em;">Baltimore 21230</span>                                                           |  | 42. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">Baltimore 21230</span>                                                                                                                                                                                                                                                                                                                                                 |  |
| 43. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.2em;">NOV 15 1971</span>                                                 |  | 44. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">Curtis E. Evans</span>                                                                       |  | 45. FUNERAL DIRECTOR<br><span style="font-size: 1.2em;">Curtis E. Evans</span>                                                                                                                                                                                                                                                                                                                                                                         |  |

3000 2 HANCOCK ST  
BOSTON MA 02130

Five Mrs

Henry  
Daniel J. Brady

Mr

119 N. Beacon St  
Boston MA 02116

2nd/10/52

Beacon St

Mr & Mrs

818-01-3018/143

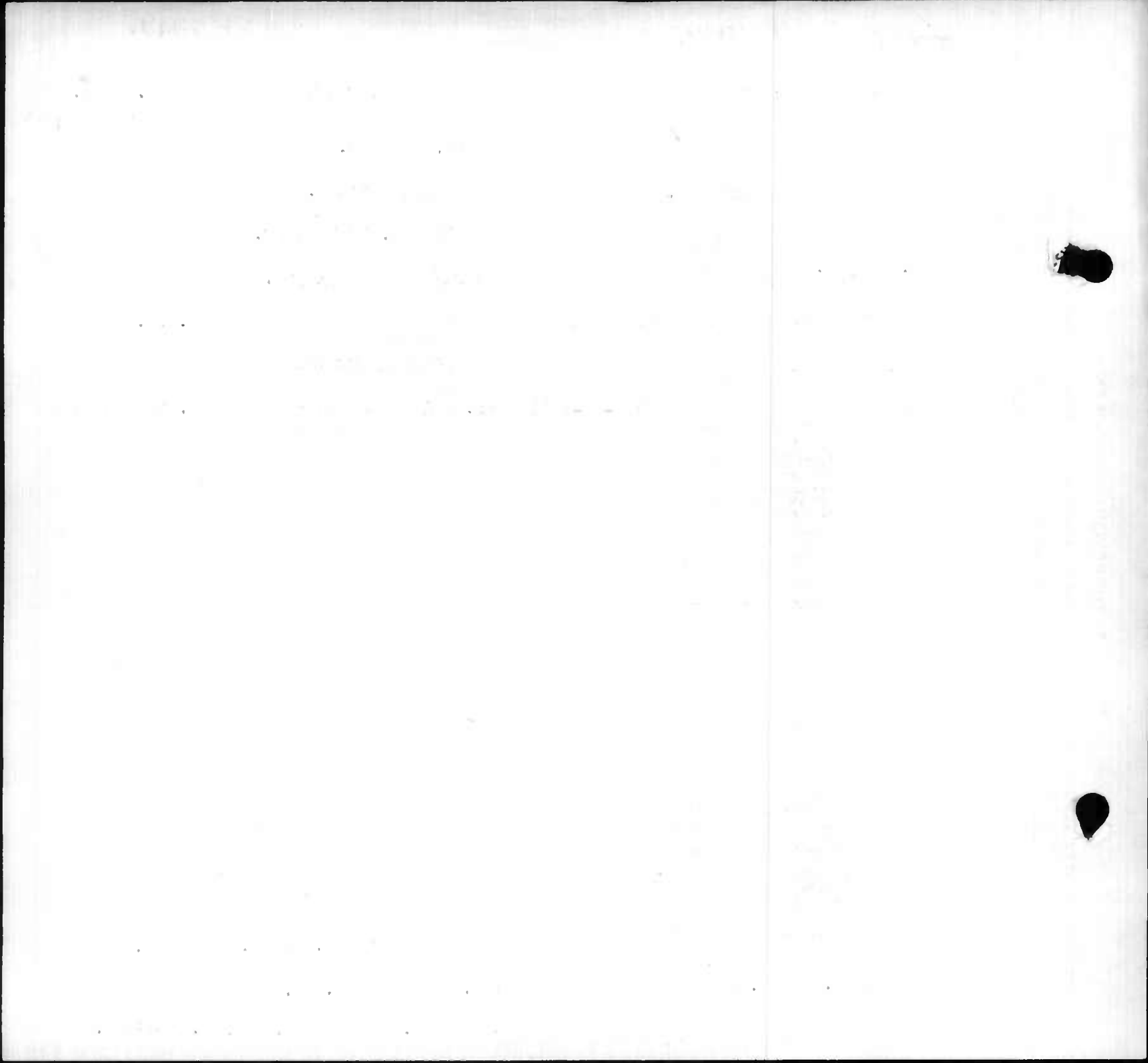
James J. Brady

Director of the  
Bureau of the Census

# FUNERAL DIRECTOR: IMPORTANT

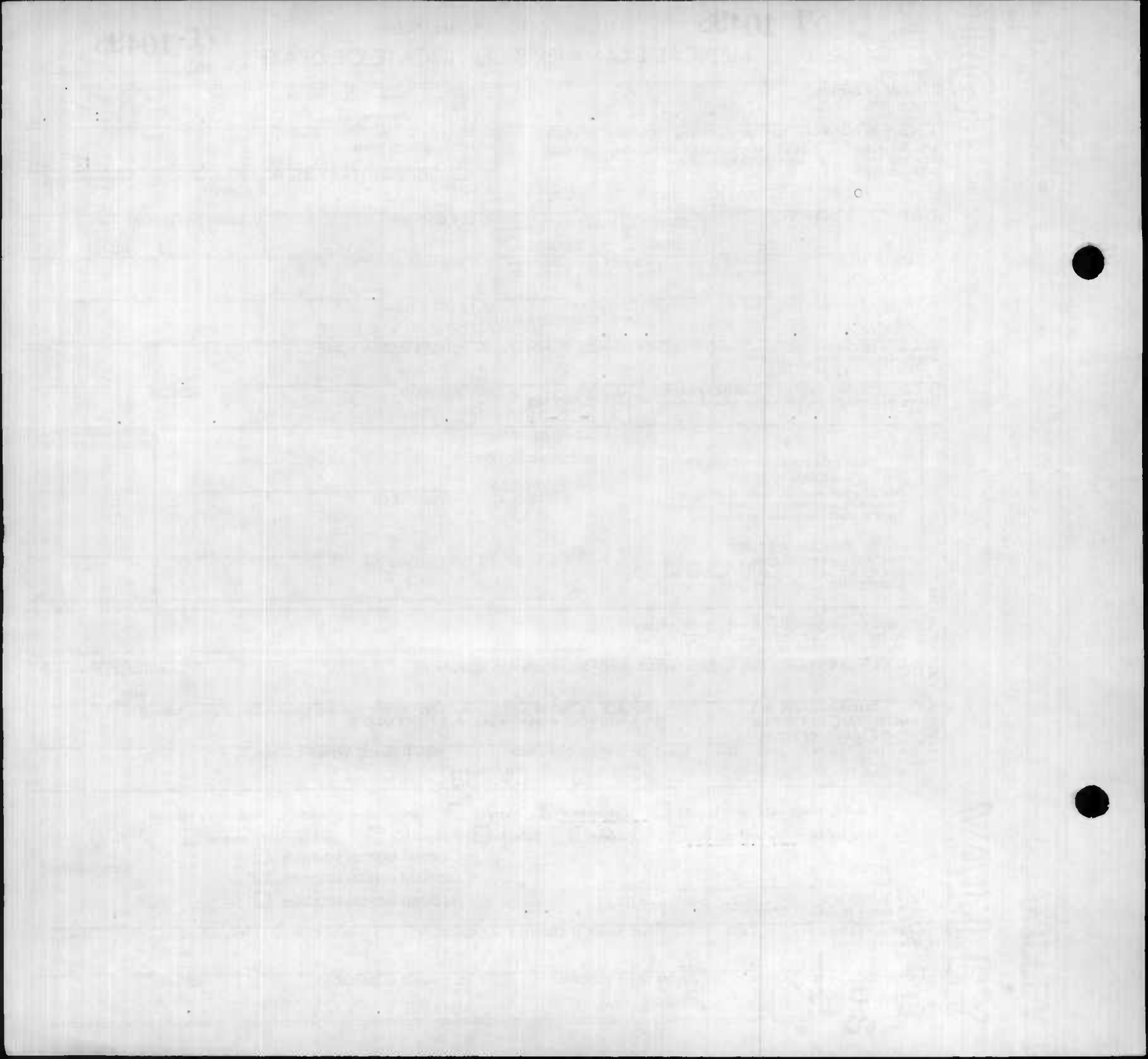
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                 |                             |                                                                                                                                                                                                                                                                                                                                                 |  | REG. NO. <u>71 10497</u>                                                        |                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|----------------------------------------------------------|
| <u>7-652</u> <u>71 10497</u><br><b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <u>ANTONINO FRANCO</u>                                                                                                                                                                                                                                                 |                             | <b>2. DATE AND HOUR OF DEATH</b><br><u>11/13/71</u> <u>5.15</u> A.M.                                                                                                                                                                                                                                                                            |  |                                                                                 |                                                          |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location)<br><u>35 CHURCH HOME HOS.</u>                                                                                                                                                      |                             | <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Md.</u> B. COUNTY <u>BALTO.</u><br><b>C. CITY OR TOWN</b> <u>BALTO.</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>E. STREET AND NUMBER</b> <u>1000 E. LOMBARD ST.</u> |  |                                                                                 |                                                          |
| <b>5. SEX</b><br><u>M.</u>                                                                                                                                                                                                                                                                                                                                               | <b>6. RACE</b><br><u>W.</u> | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>                                                                                                                                                         |  | <b>8. DATE OF BIRTH</b><br><u>3/21/09</u>                                       | <b>9. AGE</b> (In years last birthday)<br><u>72 yrs.</u> |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>CRANE OPERATOR</u>                                                                                                                                                                                                                                              |                             | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><u>RETIRED- STEEL</u>                                                                                                                                                                                                                                                                               |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>ITALY</u>                |                                                          |
| <b>13. FATHER'S NAME</b><br><u>ANTONIO FRANCO</u>                                                                                                                                                                                                                                                                                                                        |                             | <b>14. MOTHER'S MAIDEN NAME</b><br><u>MAURGARITA GERBINO</u>                                                                                                                                                                                                                                                                                    |  |                                                                                 |                                                          |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>                                                                                                                                                                                                                                          |                             | <b>16. SOCIAL SECURITY NO.</b><br><u>215-01-7158</u>                                                                                                                                                                                                                                                                                            |  | <b>17. INFORMANT</b><br><u>MR. SALVATORE MARRELLA</u>                           |                                                          |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)<br><u>269.9 I</u><br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                             | <b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE <u>Electrolyte imbalance</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <u>renal malnutrition</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C)                                                                                                                                                         |  | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>                             |                                                          |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>                                                                                                                                                                                                                     |                             |                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                 |                                                          |
| <b>19A. DATE OF OPERATION</b><br><u>6</u>                                                                                                                                                                                                                                                                                                                                |                             | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br><u>-</u>                                                                                                                                                                                                                                                                             |  | <b>20A. AUTOPSY?</b> (Yes or No)                                                |                                                          |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Indicate medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                  |                             | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                 |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) |                                                          |
| <b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                         |                             | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                |  | <b>21F. HOW DID INJURY OCCUR?</b>                                               |                                                          |
| <b>22. I certify that (I) (this hospital) attended the deceased from <u>11-6</u> 19 <u>71</u> to <u>11-13</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>11-13</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>           |                             |                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                 |                                                          |
| <b>23A. SIGNATURE</b><br><u>Corazon Vergara MD</u>                                                                                                                                                                                                                                                                                                                       |                             | <b>23B. DATE SIGNED</b><br><u>11-13-71</u>                                                                                                                                                                                                                                                                                                      |  | <b>23C. PHYSICIAN'S NAME</b> (Type)<br><u>CORAZON VERGARA</u>                   |                                                          |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><u>BURIAL.</u>                                                                                                                                                                                                                                                                                                        |                             | <b>24B. DATE</b><br><u>NOV. 16/71</u>                                                                                                                                                                                                                                                                                                           |  | <b>24C. NAME of CEMETERY or CREMATORY</b><br><u>HOLY REDEEMER CEM.</u>          |                                                          |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br><u>BALTO. Md.</u>                                                                                                                                                                                                                                                                                                |                             | <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><u>NOV 15 1971</u>                                                                                                                                                                                                                                                                                    |  |                                                                                 |                                                          |
| <b>25B. NAME OF REGISTRAR</b><br><u>Robert E. Tabor, M.D.</u>                                                                                                                                                                                                                                                                                                            |                             | <b>25C. FUNERAL DIRECTOR</b><br><u>JEROME M. DELLA NOCE.</u>                                                                                                                                                                                                                                                                                    |  |                                                                                 |                                                          |
| <b>25D. ADDRESS</b><br><u>322 S. HIGH ST.</u>                                                                                                                                                                                                                                                                                                                            |                             | <b>VS 150-REV. 1/1/68</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                 |                                                          |





| 11-450                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 71 10498 |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                     |  | 71 10498                                                                                                                                                    |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |          |  |                                                                                                                                                      |  | REG. NO.                                                                                                                                                    |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>JAMES MULLEN SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |          |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> November 11, 1971 12:15 A.M. |  |                                                                                                                                                             |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>43 South Baltimore General Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |          |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>November 11, 1971 12:15 A.M.                                                                       |  |                                                                                                                                                             |  |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |          |  | 7. RACE<br>White                                                                                                                                     |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br>12/29/24                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |          |  | 10. AGE (In years last birthday)<br>46                                                                                                               |  | 11. BIRTHPLACE (State or foreign country)<br>BALTO. Md.                                                                                                     |  |
| 12. CITIZEN OF<br>U.S.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |          |  | 13. FATHER'S NAME<br>FREDERICK MULLEN                                                                                                                |  | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 2301                                  |  |
| 15. MOTHER'S MAIDEN NAME<br>ELIZABETH MC MANUS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |          |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>YES. W.W. II                           |  |                                                                                                                                                             |  |
| 17. SOCIAL SECURITY NO.<br>219-18-1576                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |          |  | 18. INFORMANT<br>MRS. PATRICIA MULLEN 14 W. WEST ST.                                                                                                 |  |                                                                                                                                                             |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic cardiovascular disease<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  |          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                         |  |                                                                                                                                                             |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |          |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |  |                                                                                                                                                             |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                  |  |          |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                             |  |                                                                                                                                                             |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |          |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                            |  |                                                                                                                                                             |  |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |          |  | 21. AUTOPSY? (Yes or No)<br>No                                                                                                                       |  |                                                                                                                                                             |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                                                                         |  |          |  | 24. DATE<br>NOV. 15/71                                                                                                                               |  |                                                                                                                                                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |          |  | 24C. NAME OF CEMETERY or CREMATORY<br>CREST LAWN                                                                                                     |  |                                                                                                                                                             |  |
| 24B. DATE<br>NOV. 15/71                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |          |  | 24D. LOCATION (City, town, or county) (State)<br>MARRIOTSVILLE HOWARD COU                                                                            |  |                                                                                                                                                             |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 15 1971                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |          |  | 25B. NAME OF REGISTRAR<br>Robert E. Miller, M.D.                                                                                                     |  |                                                                                                                                                             |  |
| 25C. FUNERAL DIRECTOR<br>JEROME M. DELLA NOCE 322 S. HIGH ST                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |          |  | 25D. NAME OF REGISTRAR<br>JEROME M. DELLA NOCE 322 S. HIGH ST                                                                                        |  |                                                                                                                                                             |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                             |                  | REG. NO. <b>71 10499</b>                                                                      |                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------|----------------------------------------|
| L-300 <b>71 10499</b>                                                                                                                                                                                                                                                                                                                                |              |                                                                                                                                                             |                  |                                                                                               |                                        |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                            |              | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                      |                  | 2. DATE AND HOUR OF DEATH                                                                     |                                        |
|                                                                                                                                                                                                                                                                                                                                                      |              | <b>BRODIE LYDE</b>                                                                                                                                          |                  | <b>11-13-71 2:25 P M.</b>                                                                     |                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                               |              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE B. COUNTY                                                 |                  |                                                                                               |                                        |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)                                                                                                                                                                                                                                            |              | MARYLAND                                                                                                                                                    |                  | 908                                                                                           |                                        |
| <b>33 THE JOHNS HOPKINS HOSPITAL<br/>BALTIMORE, MARYLAND 21205</b>                                                                                                                                                                                                                                                                                   |              | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                         |                  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                        |
|                                                                                                                                                                                                                                                                                                                                                      |              | E. STREET AND NUMBER<br><b>1227 E. NORTH AVE.</b>                                                                                                           |                  |                                                                                               |                                        |
| 5. SEX                                                                                                                                                                                                                                                                                                                                               | 6. RACE      | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday)                                                               | 10. Under 1 Yr. Months Days Hours Min. |
| <b>MALE</b>                                                                                                                                                                                                                                                                                                                                          | <b>NEGRO</b> |                                                                                                                                                             | <b>02/18/10</b>  | <b>61</b>                                                                                     |                                        |
| 10A. USUAL OCCUPATION (Give kind of work done (bring most of working life, even if retired))                                                                                                                                                                                                                                                         |              | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                  | 11. BIRTHPLACE (State or foreign country)                                                     |                                        |
| <b>Laborer</b>                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                             |                  | <b>Hartsville S.C.</b>                                                                        |                                        |
| 13. FATHER'S NAME<br><b>EDWARD LYDE</b>                                                                                                                                                                                                                                                                                                              |              | 14. MOTHER'S MAIDEN NAME<br><b>ELLA ALLEN</b>                                                                                                               |                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                   |                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                |              | 16. SOCIAL SECURITY NO.<br><b>248 03 4677</b>                                                                                                               |                  | 17. INFORMANT<br><b>Yvonne Lyde</b>                                                           |                                        |
|                                                                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                             |                  | ADDRESS<br><b>1227 E. North Ave</b>                                                           |                                        |
| 18. <b>43671</b>                                                                                                                                                                                                                                                                                                                                     |              | CAUSE OF DEATH                                                                                                                                              |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |                                        |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                       |              | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                      |                  | <b>Aspiration of Gastric Contents 1/2 hr</b>                                                  |                                        |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                       |              | (B) <b>CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                           |                  | <b>4 mos</b>                                                                                  |                                        |
|                                                                                                                                                                                                                                                                                                                                                      |              | (C)                                                                                                                                                         |                  |                                                                                               |                                        |
| II                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                             |                  |                                                                                               |                                        |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>none</b>                                                                                                                                                                                                      |              |                                                                                                                                                             |                  |                                                                                               |                                        |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                               |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                  | 20A. AUTOPSY? (Yes or No)                                                                     |                                        |
|                                                                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                             |                  | <b>no</b>                                                                                     |                                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                        |
| <b>no</b>                                                                                                                                                                                                                                                                                                                                            |              | <b>no</b>                                                                                                                                                   |                  |                                                                                               |                                        |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                            |              | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                  | 21F. HOW DID INJURY OCCUR?                                                                    |                                        |
|                                                                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                             |                  |                                                                                               |                                        |
| 22. I certify that (I) (this hospital) attended the deceased from <b>October 29 19 71</b> to <b>November 13 19 71</b> that (I) (we) last saw the deceased alive on <b>November 13 19 71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |              |                                                                                                                                                             |                  |                                                                                               |                                        |
| 23A. SIGNATURE<br><b>S. D. Nightingale</b>                                                                                                                                                                                                                                                                                                           |              | 23B. DATE SIGNED<br><b>Nov 13 1971</b>                                                                                                                      |                  | 23C. PHYSICIAN'S NAME (Type)<br><b>S. D. NIGHTINGALE</b>                                      |                                        |
|                                                                                                                                                                                                                                                                                                                                                      |              | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                             |                  |                                                                                               |                                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                             |              | 24B. DATE                                                                                                                                                   |                  | 24C. NAME of CEMETERY or CREMATORY                                                            |                                        |
| <b>Burial</b>                                                                                                                                                                                                                                                                                                                                        |              | <b>11/21/71</b>                                                                                                                                             |                  | <b>Centerville Am. Cemetery Hartsville S.C.</b>                                               |                                        |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>NOV 15 1971</b>                                                                                                                                                                                                                                                                                                |              | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, Jr.</b>                                                                                                      |                  | 25C. FUNERAL DIRECTOR<br><b>Young &amp; Young</b>                                             |                                        |
|                                                                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                             |                  | ADDRESS<br><b>1907 6th St.</b>                                                                |                                        |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                              |  |                                                                                                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| E-420 71 10500                                                                                                                                                                                                                                                                                                                                                                                                                             |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                             |  | REG. NO. 71 10500                                                                                                                                           |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | CERTIFICATE OF DEATH                                                                                                         |  |                                                                                                                                                             |  |
| 1. NAME OF DECEASED<br>(Type or Print) Francis Ellis                                                                                                                                                                                                                                                                                                                                                                                       |  | 2. DATE AND HOUR OF DEATH<br>11-12-71 10:30 A.M.                                                                             |  |                                                                                                                                                             |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>37 Mercy Hospital                                                                                                                                                                                                                                               |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE B. COUNTY<br>Maryland 2748 |  |                                                                                                                                                             |  |
| 5. SEX Male                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 6. RACE White                                                                                                                |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br>10-27-99                                                                                                                                                                                                                                                                                                                                                                                                               |  | 9. AGE (in years last birthday) 71                                                                                           |  | 10. UNDER 1 Yr. Months Days If Under 24 Hrs. Hours Min.                                                                                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Gas & Elec Co.                                                                          |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                       |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U S A                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13. FATHER'S NAME<br>Ellis                                                                                                   |  | 14. MOTHER'S MAIDEN NAME<br>Unknown                                                                                                                         |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>Yes War 11                                                                                                                                                                                                                                                                                                                     |  | 16. SOCIAL SECURITY NO.<br>212-05-4322                                                                                       |  | 17. INFORMANT<br>Mrs. Amelia Ellis 1247 Northern Parkway                                                                                                    |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Bunchworm<br>Ca of lung<br>Antecedent Causes<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>Pneumonia to liver<br>Cerebellar metastases?<br>Intermittent Heart Dis. |  | CAUSE OF DEATH                                                                                                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 months<br>11<br>6 years                                                                                   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                           |  |                                                                                                                              |  |                                                                                                                                                             |  |
| 19A. DATE OF OPERATION<br>21 0                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                             |  | 20A. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                           |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                             |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                     |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                       |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 1960 to 11/12/71 that (I) (we) last saw the deceased alive on 11/11/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 10:30 am                                                                                                                                 |  |                                                                                                                              |  |                                                                                                                                                             |  |
| 23A. SIGNATURE<br>Sol Smith                                                                                                                                                                                                                                                                                                                                                                                                                |  | 23B. DATE SIGNED<br>11/12/71                                                                                                 |  | 23C. PHYSICIAN'S NAME (Type)<br>Sol Smith                                                                                                                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                         |  | 24B. DATE<br>11-16-71                                                                                                        |  | 24C. NAME of CEMETERY or CREMATORY<br>Oak Lawn Cemetery                                                                                                     |  |
| 24D. LOCATION<br>Eastern Ave Balto, Md                                                                                                                                                                                                                                                                                                                                                                                                     |  | 25A. DATE REC'D BY HEALTH DEPT.<br>NOV 15 1971                                                                               |  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, M.D.                                                                                                            |  |
| 25C. FUNERAL DIRECTOR<br>Frederick J. Cook 7200 Harford Rd                                                                                                                                                                                                                                                                                                                                                                                 |  | 25D. ADDRESS                                                                                                                 |  |                                                                                                                                                             |  |

